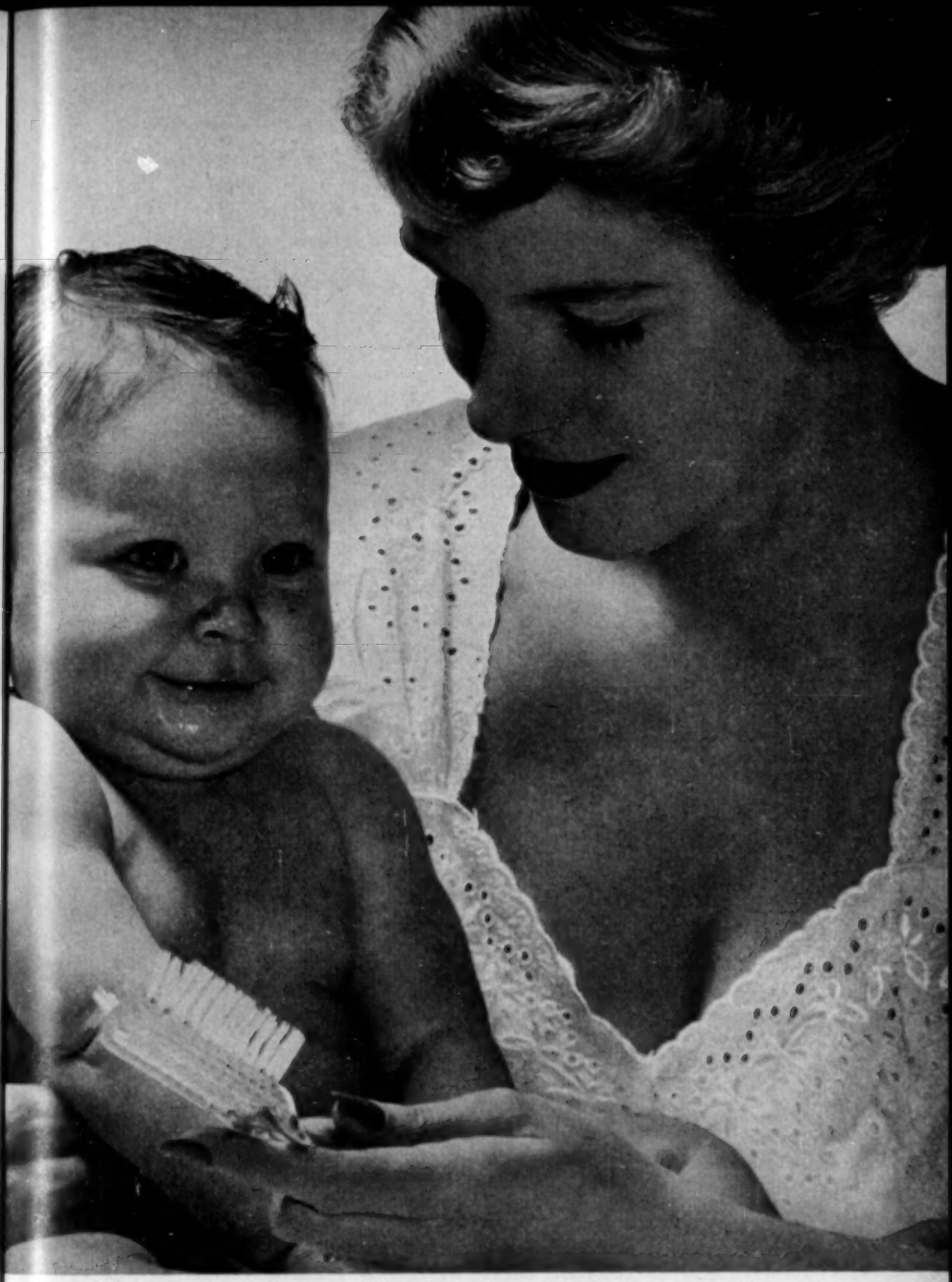

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In psychiatric hospitals, the shortage of professional nurses who are well qualified for this branch of nursing service is almost devastatingly acute. The incidence of mental illness is so great that special consideration is demanded of us as an association to determine how this problem may be met. This was the driving force behind the study made during the past biennium by the Educational Policy Committee of the C.N.A. **Evelyn Mallory's** lengthy report is worthy of careful study by every thinking nurse.

The same urge to share thinking on this problem led to the development of the panel discussion at the convention in Banff. Dr. C. A. Roberts is intensely interested in maintaining an active liaison with our national association. He is even more concerned with finding an adequate solution to the staffing problem. What do you think about the method of attacking this problem that he has presented? The papers of the other panel participants are included here also.

* * *

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* * *

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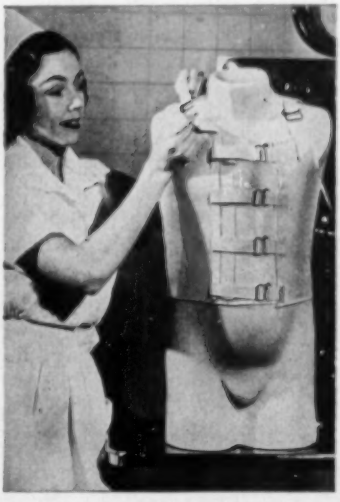

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PUBLISHED BY THE CANADIAN NURSES' ASSOCIATION
VOLUME 50 NUMBER 11
MONTREAL, NOVEMBER, 1954

The Preparation of Nursing Personnel for the Care of the Mentally Ill

H. Evelyn Mallory

Introduction

In the latter part of 1950 a director of nursing service in one of our provincial mental hospitals expressed her concern over two related developments: (1) the increasingly strained relations between the "registered" nurses and the relatively much larger numbers of personnel participating in the nursing care of patients in mental hospitals; and (2) the wide variation across Canada in the programs for the preparation of the latter group. This problem was presented through the appropriate channels to the Executive Committee of the Canadian Nurses' Association in February 1951, at which time it was agreed:

> That the question of standards of training for the non-professional group of psychiatric nurses shall be referred to the provincial nurses' associations for a definition of the situation as they see it in their respective provinces.

This was done through National Office and in August the replies were referred "for assessment" to the Committee on Educational Policy. Though all provinces responded to the request for information, on the whole the replies did not give the kind of information desired (probably because in many instances there were no organized programs to report) and it was not possible to do anything with the information received. Therefore, when reporting the matter to the C.N.A. in June, 1952, the Committee on Educational Policy made the following recommendation which was endorsed by the General Meeting:

> Whereas, The nursing profession has a responsibility for the standard of nursing care in psychiatric hospitals, and
>
> Whereas, The whole situation of the training and status of personnel for the nursing care of psychiatric patients is confused and involved, and
>
> Whereas, Professional nurses who are responsible for the nursing service in psychiatric hospitals are seeking assistance from the Canadian Nurses' Association, therefore be it
>
> *Resolved*, That a special committee be appointed to study the problem of the preparation of non-professional psychia-

Miss Mallory, who is director of the School of Nursing, University of B.C., Vancouver, is Chairman of the C.N.A. Committee on Nursing Education.

tric nursing personnel and that provision be made for bringing the committee together to work on this problem.

Inasmuch as the resolution called for the setting up of a special committee and involved the expenditure of funds, the matter had then passed beyond the jurisdiction of the Committee on Educational Policy. However, at an early date the Committee was asked to make recommendations regarding the personnel of the special committee to act on the resolution. When the members of the Committee on Educational Policy considered the matter they became convinced that the preparation of other categories of nursing personnel could not be considered apart from the preparation of the registered nurse, since the efforts of all nurses must be effectively coordinated if the best interests of the patient are to be served. This viewpoint appeared to be reinforced by a second resolution which had been endorsed at the 1952 biennial meeting, namely:

WHEREAS, The need for experience in psychiatric nursing has been emphasized in the Report of the Evaluation of the Metropolitan School of Nursing and is an important aspect of the basic preparation of the professional nurse, a need that cannot be met without satisfactory practice fields in psychiatric hospitals, therefore be it

Resolved, That every effort be made to establish practice fields and to encourage the inclusion of psychiatric experience in the basic professional course.

The Committee therefore made the following recommendation which was approved by the Executive Committee at a meeting held in January, 1953:

That the functions of the Committee be expanded to include a study and the making of recommendations, within the framework of the C.N.A. statement of educational policies, concerning the preparation of auxiliary and professional personnel designed to provide more adequate nursing care for the mentally ill.

For two reasons, Miss Marjorie Russell was selected to act as chairman of this committee; first, because she had done such good work during the previous biennium on a somewhat similar assignment, and secondly, because there seemed to be a very close relationship between these two assignments and it was felt that her background of knowledge would be of value to the new committee. Miss Russell very kindly consented and her committee, with representatives from various parts of the country as well as Miss Marjorie Keyes of the Canadian Mental Health Association and Miss Edith Kemp who had been serving on a national government committee engaged in study of the same problem, was brought together in Toronto. Here, with the president and general secretary of the C.N.A., this special committee spent four days exploring the difficult problem which had been assigned to them. When one considers the immensity and the complexity of their task one is much impressed by the committee's report. It emphasized the acuteness of the problem by quoting statistics relative to the numbers of patients in mental hospitals and the available supply of nurses of all categories to care for them. It highlighted some of the reasons for the shortage of nurses in mental hospitals. It included recommendations, both general and specific, designed to effect improvement. It emphasized the urgent need for the C.N.A. and other interested groups to coordinate their efforts in order to achieve better nursing care of patients in mental hospitals.

In June, 1953, a two-day meeting of the Committee on Educational Policy was called in Toronto, chiefly for the purpose of studying the report of Miss Russell's committee. At this time it was recommended that an informal progress report be prepared and submitted to Dr. Roberts, chief of the Division of Mental Health of the Department of National Health and Welfare. This was done in September, 1953. Also at the Toronto meeting it was decided to recommend to the Executive:

That the C.N.A. Committee on Employment Relations be asked to obtain from psychiatric hospitals information as to the status, salaries and staff relations of the registered nurse and the "psychiatric nurse," both male and

female, so that the C.N.A. may have factual data to be used in support of the recommendations made concerning the preparation of nursing personnel for the care of mentally ill patients.

This resolution was approved and the Committee on Employment Relations now has the task in hand.

Included in the report of Miss Russell's committee was the recommendation, "That the revision of the curriculum$_2$ be commenced without delay to lay more emphasis on the integration of psychiatric concepts with general training." The conclusion reached by the Committee on Educational Policy in regard to this recommendation was that, though such action might be highly desirable, in view of the fact that curriculum revision is a gigantic task and the C.N.A. was still without an educational secretary in National Office it was not feasible at that time. Therefore, two sub-committees were appointed:

One, under the chairmanship of Miss Nettie Fidler, to make specific recommendations as to how psychiatric emphasis might be more effectively integrated into the basic professional curriculum, and the other, under the chairmanship of Miss Edith Dick, to make recommendations as to how psychiatric emphasis might be integrated into the curriculum for the preparation of the nursing assistant (or practical nurse.)

Thus, when the Committee on Educational Policy met in October, 1953, the members had before them for consideration the reports from three separate committees. Each had given attention to a different aspect of the same problem. Each contained valuable recommendations. Inevitably there were duplications, contradictions, and some inconsistencies with C.N.A. policy. Therefore the next step was to find a person who had the time and the ability to coordinate these materials into one composite report. Mrs. Dorothy (Duff) Nelson, formerly on the staff of the University of Toronto School of Nursing, consented to undertake this task — not an easy one. The Committee on Educational Policy would like to record its appreciation.

The final report was of necessity written by the chairman in consultation with "core" members of the committee. In its preparation she has endeavored to interpret the intent of the several contributing committee reports. This report therefore represents the efforts of many people. It is not the report of a comprehensive study which, much as it may be needed, could not be undertaken by busy people in the time they were able to spare from their primary responsibilities. The report is the effort to crystallize the conclusions reached by a group of individuals who have tried to share their thinking in relation to the problem assigned to them. If it is considered an unsatisfactory report, as it may be in some quarters, at least there is the satisfaction of knowing that the problem has been "wrestled with," and that perhaps a necessary foundation has been laid on which another committee can build something more constructive.

The committee realizes that it has done both less and more than was implied in the resolution approved by the 1952 biennial meeting — less, in that the report does not contain, as may have been expected, a recommended pattern or curriculum for the preparation of non-professional psychiatric nurses; more, in that the committee has viewed the problem in its broader aspects and has made the only recommendations that seemed tenable in the light of the C.N.A's policies on nursing education.

As has already been stated, the problem of how to provide more adequate nursing care for the patients in our mental hospitals is very complex and very difficult. It has been with us and will continue to be with us for a long time. That it now appears to be more acute than formerly is perhaps an encouraging sign. We would like to think it indicates a greater awareness, not only on the part of those responsible for providing health services but on the part of the general public as well, of the importance of mental health and of finding more effective measures, both preventive and curative, for the promotion of mental health. The one obvious and ineluctable conclusion to

be drawn is that the nursing aspects of this problem cannot be solved quickly and cannot be solved by nurses alone, but only by our working patiently and over a long period of time in cooperation with all other groups concerned.

General Statement of the Problem

A study of the reports on "Mental Institutions" published by the Dominion Bureau of Statistics reveals that mental illness is on the increase.

In 1951, out of every 10,000 persons in Canada, 43.09 were "patients under care"[3] for mental illness. This is a slight increase over the rate (42.99) for the previous year, and a noticeable increase over the average rate (36.53) for the four-year period from 1932-1936.

These figures appear to indicate that the number of mentally ill patients requiring care is not likely to decrease in the near future. In support of this evidence we find that new psychiatric hospitals are being constructed, psychiatric units opened in general hospitals, and "day care"[4] programs extended. In addition, the treatment of psychiatric patients is no longer confined to institutions but is being extended out into the community. Mental health clinics are increasing in number, and psychiatrists are entering private practice.

Skilled nursing is needed for all of these services.

In 1950 the daily average number of patients in all hospitals was 117,326. Of these, 54,240 (46.23%) were in hospitals for the mentally ill[5].

The committee had very little information on the nursing service in psychiatric hospitals. To obtain adequate information would have been very difficult and would have entailed actual visits and the expenditure of considerable time in each hospital. But even without a careful survey it is safe to say that the nursing service in these hospitals is in a critical and confused state. According to the Dominion Bureau of Statistics, in 1950, the nursing care of 54,240 patients was provided by:

901 registered nurses.

1,053 non-registered graduate nurses of varied qualifications. In this group would probably be included graduate nurses unable to meet registration requirements; and a large number of "psychiatric nurses" who completed courses of one, two, or three years.

1,449 students. The report states that "affiliating students" were not included. One assumes therefore that the students referred to were pursuing a variety of courses provided in and by the psychiatric hospitals.

4,567 aides and attendants.

This means that to take care of the entire nursing service on a 24-hour basis, there were 1 nurse for every 60 patients and 1 attendant for every 8.5 patients. The American Psychiatric Association states that safe nursing requires 1 nurse for every 6 patients and 1 attendant for every 4 patients.[6]

Modern concepts of psychiatric treatment call for highly skilled nursing, but with the acute shortage of staff indicated by these figures little more than custodial care is possible.

Today the shortage of nurses appears to be world wide, though the awareness of need and therefore the degree of apparent shortage varies tremendously in different countries. There can be little doubt, however, that in Canada the shortage is most acute in psychiatric hospitals. Here, faced with inability to procure qualified staff and with an increasing demand for more and better nursing, many hospitals have been forced to recruit and prepare what staff they could, and have done so in a variety of ways. As a result many workers are carrying nursing responsibilities for which they have had little or no preparation.

In the opinion of the Committee the following factors, brought out during discussion of the problem, have a definite bearing on the difficulty experienced in trying to secure registered nurses for staff positions in psychiatric hospitals:

1. *Inadequate preparation of the nurse for this kind of service.* Despite the fact that the "Proposed Curriculum for Schools of Nursing" published by the C.N.A. in 1936, recommended that all

students be given instruction and experience in psychiatric nursing, the majority of schools offering the basic nursing course do not yet provide their students with such experience. Reasons for this lag appear to include:

(a) Reluctance on the part of general hospitals to release their students to other institutions, due to the shortage of personnel in their own hospitals.

(b) The fact that there are inadequate facilities in psychiatric hospitals for the provision of a satisfactory student program, e.g., residence accommodation for students, and qualified instructional and supervisory staff. These conditions deter efforts to make experience in psychiatric nursing a legal requirement for registration. Until this is done, however, the situation is likely to continue unchanged.

2. The *relative isolation* of many psychiatric hospitals in small towns and rural areas presents disadvantages to the nurse in the form of limited social and recreational opportunities.

3. The *lack of understanding* of mental illness on the part of the community as a whole probably tends to discourage nurses from entering this field when other more attractive opportunities for employment are plentiful.

4. Relatively *greater frustrations* are encountered by the registered nurse who goes from a general hospital to a psychiatric hospital:

(a) Satisfactory facilities for giving good nursing care to patients are often lacking.

(b) Nurses often feel that knowledge and experience which they gained through their general preparation are not appreciated or used to advantage.

(c) Male attendants frequently enjoy a status and remuneration comparable to that of the registered nurse although their preparation is less extensive.

(d) Unsatisfactory administrative policies and practices arise from the fact that in some hospitals overall responsibility for nursing service is divided rather than centred in the director of nursing whose jurisdiction over nursing personnel may be confined to the women's division.

(e) Unsatisfactory working relationships often exist between the registered nurse who has had limited preparation in psychiatric nursing and the "psychiatric nurse" who has received all her preparation in an institution for the mentally ill.

5. Registered nurses, who have had no definite experience in psychiatric nursing but might be interested in the field, are barred from employment in some psychiatric hospitals because psychiatric nursing experience is a prerequisite for employment.

Auxiliary nursing personnel (i.e., nurses other than registered nurses) constitutes by far the largest number of workers caring for the mentally ill. Their preparation varies tremendously, ranging from little or practically none to the completion of a three-year course. Organized courses in psychiatric nursing offered by the several provincial mental hospitals vary in length from one to three years. The committee did not attempt to study the content of these courses. Two provinces, British Columbia and Saskatchewan, have legislation which confers legal status by granting a license to practise as a "psychiatric nurse" to the individual who graduates from the school maintained by the provincial mental hospital. A third province, Alberta, is considering similar legislation. Since these nurses do not meet requirements for registration, their opportunities for advancement are limited. These nurses are a vital part of the health services of their respective provinces and many of them feel that this fact is not sufficiently recognized by the professional group or by the general public. The number of graduates from the provincial mental hospital schools is inadequate to meet the need. It is doubtful if under present conditions their number can be increased sufficiently to do so. This whole problem needs very careful study.

Bearing in mind the terms of reference which were "to study and make recommendations, within the framework of the Canadian Nurses' Association statement of educational policies,

concerning the preparation of auxiliary and professional personnel designed to provide more adequate nursing care for the mentally ill," the committee then reviewed the policies. That section most pertinent to the problem appeared to be the following:

> There is need in the overall field of nursing service for different categories of workers and, therefore, for differentiation of preparation but:
>
> (a) Standards of education and practice are definitely the responsibility of the professional group.
>
> (b) All schools and programs of nursing education should be approved by appropriate provincial approving agencies, and by a national approving agency, on a voluntary basis, when one is established.
>
> (c) The basic preparation for both the professional nurse and the nursing assistant should be general rather than specialized. This would mean that any further preparation needed to fit them for work in a specialized field (e.g., in a psychiatric hospital or a tuberculosis hospital) should be provided through "orientation" programs and "on-the-job" training.
>
> (d) Courses for graduate nurses should be developed and directed by universities rather than by hospitals. Hospitals, rich in clinical resources appropriate for graduate nurse programs, should cooperate by making their resources available to the universities but responsibility for the educational programs should rest entirely with the university.

It is the opinion of the committee that the recommendations submitted herewith are in line with the above policy.

Recommendations

Part I: In Relation to the Preparation of the Professional Nurse: It is recommended that the basic professional curriculum in all schools of nursing be revised to provide for greater emphasis on psychiatric nursing.

The implementation of this recommendation requires clarity of purpose, adequate facilities including an appropriate clinical field, a carefully planned program, and qualified staff. With regard to these factors the committee submits the following recommendations:

A. That the aims of the course in psychiatric nursing be:

1. To help students develop an understanding of human behavior, both personal and social. This should include an understanding of normal psychological growth and devolpment, and a recognition of deviations from good mental health; an understanding of interpersonal relationships; a knowledge of the causes, the means of prevention, and the treatment of mental disorders.

2. To give students a better preparation for all nursing and, more specifically, to prepare them for first level positions in psychiatric nursing (as is the aim of the basic course in relation to other fields of nursing).

B. That all possible action be taken to secure improved facilities for teaching psychiatric nursing, the essential facilities being:

1. Satisfactory residence accommodation and living conditions for students. Psychiatric hospitals should be urged to provide more residence accommodation for students, and in doing so to consider the needs of at least three categories of students — graduate nurses, professional nursing students, and nursing assistants.

2. Classrooms and other physical facilities essential for teaching and learning.

3. Clinical fields where teaching and supervisory staff are adequate in numbers and qualifications.

4. A reasonable timetable for students, one that recognizes the facts that the student needs to learn and that learning requires time for independent study, classroom instruction, and planned and guided clinical experience.

C. That emphasis on psychiatric nursing permeate the entire nursing curriculum.

1. The first approach should be on nursing as an interpersonal process in order that the total needs of the patient may be recognized, understood and met. To achieve this, courses in psychology and mental hygiene should be taught early and there should be continuing emphasis on the social aspects of nursing

in all courses of the curriculum.

2. The psychiatric factors in the illness of the patient should be taken into account in all the teaching of nursing.

3. So that she may apply her learning to the care of all patients, the student should have her experience in psychiatric nursing as early as possible. In this connection:

(a) The school should provide a few days for orientation prior to the actual psychiatric nursing experience.

(b) If the experience is to be gained through affiliation in a psychiatric hospital, the time should be spent largely with early and acutely ill patients but students should not be placed with violently disturbed and inaccessible patients.

(c) Experiences in the mental health clinic in the outpatient department, in the continued treatment section, and in learning to help the unoccupied patients through occupational therapy are of value.

(d) If a general hospital has a unit admitting psychoneurotic and mildly ill patients, the student might have half of her experience there and the other half with seriously ill and chronically ill patients at a psychiatric hospital.

(e) Observation visits to the community should be planned, e.g., to child guidance and mental health clinics.

4. Emphasis on psychiatric aspects of nursing should be continued after the student has completed her block of psychiatric nursing experience per se. More secure in her understanding of patients, she should now be able to apply what she has learned and be helped and encouraged to do so in both the hospital and the public health field.

D. The carrying out of a program such as is indicated in C. above requires (1) that the directors of schools of nursing be aware of the importance of this approach to the teaching of psychiatric nursing and be willing to assist in making it possible and (2) an adequate supply of nursing instructors qualified and able to integrate the psychiatric aspects of nursing into their teaching. At the present time such persons are not generally available.

Therefore it is recommended that a concerted effort be made to see that many more nurses are specifically prepared for teaching psychiatric nursing, and that all instructors of nursing become better qualified to integrate psychiatric nursing into their teaching.

1. University courses for the preparation of nursing instructors should recognize the general weakness of the basic nursing course in relation to psychiatric nursing and should give special emphasis to this subject.

2. Financial assistance should be sought, through National Health grants and other sources, to enable graduate nurses to take university courses with emphasis on psychiatric nursing.

3. Short orientation courses in psychiatric nursing should be offered by universities with the cooperation of psychiatric hospitals for instructors now engaged in teaching nursing. To make possible such courses, financial aid should be sought.

4. Financial aid should also be made available to assist approved agencies (hospital and other) who cooperate in these programs through the provision of psychiatric nursing experience.

5. In the face of present shortages, an immediate effort should be made to provide qualified teaching and supervisory staff for a few selected departments in psychiatric hospitals so that adequate instruction and experience may be provided for more students; and, as quickly as numbers of prepared staff warrant it, the areas used for student instruction and experience should be expanded.

6. In order to help strengthen the staff in these clinical areas:

(a) Arrangements should be made whereby graduate nurses, interested in psychiatric nursing, may obtain psychiatric nursing experience in preparation for employment in psychiatric hospitals.

(b) To compensate for the relative isolation of some hospitals, attractive living quarters, facilities for social and recreational activities and, where necessary, transportation facilities should be provided.

(c) Through careful orientation, with emphasis on the important contri-

bution made by all workers, and continuous staff education, with emphasis on the team concept, effort should be directed toward the promotion of harmonious and cooperative relationships among all nursing personnel.

Part II: In Relation to the Preparation of Auxiliary Nursing Personnel: The following recommendations are made in the light of the C.N.A. policy which states that, "The basic preparation for both the professional nurse and the nursing assistant should be general rather than specialized." The committee recommends:

A. That all existing curricula for the preparation of the nursing assistant (in some provinces called the "practical nurse") be expanded to include appropriate emphasis on psychiatric nursing.

B. That it be recognized that for a psychiatric hospital to be the centre of a school for nursing assistants would be in line with C.N.A. policy provided the program were such as to include adequate preparation for the general practice of nursing on the assistant level. This would entail a definite period of experience in general nursing in at least one clinical field other than that provided by the psychiatric hospital.

In effect, "A" and "B" together signify that all schools for the preparation of auxiliary nursing personnel should provide instruction and experience in both general nursing and psychiatric nursing.

C. That, in order to promote greater uniformity in preparation, the C.N.A.'s "Report of the Special Committee to Study Auxiliary Nursing Personnel" (in which is included a recommended curriculum) be revised in line with recommendations contained in this present report; that the committee to which this task is assigned include adequate representation from the field of psychiatric nursing.

D. That steps be taken to initiate an experimental program, as indicated, for the purpose of finding out if such a program would in fact prepare workers able to adapt themselves with reasonable ease to both the general nursing and the psychiatric nursing fields.

E. That, in order to promote enrolment in the experimental program, substantial financial assistance be provided to trainees; and that consideration be given to the possibility of having the trainee's receipt of financial assistance entail an obligation for a definite period of service upon completion of the course.

F. That, in order to insure that all patients in psychiatric hospitals receive the same quality of care, the preparation of both male and female personnel be of an equivalent standard.

G. That, in order to protect the public and to provide recognition and status to nursing assistants (both male and female), it again be recommended to the provinces that they promote legislation for the licensing of those who complete an approved course.

The committee reiterates that the satisfactory implementation of these recommendations calls for a clear statement of aims, adequate facilities, a carefully planned program, and instructors who are qualified to teach and supervise. Though the working out of detailed requirements should be the responsibility of a special committee, this committee submits the following suggestions for consideration:

In broad terms, the program should be such as to prepare better nursing assistants who will be able to give better nursing care, within the limits of their training, to mildly ill, chronically ill and convalescent patients, including psychiatric patients.

Essentially the same kinds of facilities are needed for teaching this group as for teaching the professional nursing student, namely: satisfactory residence accommodation and living conditions; adequate classrooms and other physical facilities for teaching and learning; appropriate clinical fields where the trainees may have planned and supervised experience, in both general nursing and psychiatric nursing.

An emphasis on recognizing and helping to meet the total needs of the patient should permeate the entire curriculum.

All trainees should have experience in nursing psychiatric patients, possibly in the psychiatric unit of a general hospital but preferably in a psychiatric hospital where the time might be divided equally between the admitting ward and

the continued care of convalescent patients.

All trainees should become aware of existing community facilities related to the care of psychiatric patients, and that to assist in accomplishing this, observation visits to selected agencies be planned, e.g., to mental health clinics, child guidance clinics, psychiatric hospitals, etc.

Since in the kind of program visualized experience in psychiatric nursing will be an essential qualification for all who teach nursing to the assistant nurse group, instructors who now lack this preparation should be helped to obtain it; and as soon as feasible such preparation should be considered a requirement for employment in this capacity. Recommendations made in Part I of the recommendations have a direct bearing on this problem.

Part III: General Recommendations:

1. That the C.N.A. recommend to the administrators of psychiatric hospitals:

(a) That, in order to facilitate the planning and carrying out of a continuous staff education program aimed at the promotion of better interstaff relationships and the improvement of patient care, responsibility for all nursing service (both male and female) be centred in the director of nursing.

(b) That, where new buildings or renovations of present buildings are contemplated, the Department of Nursing of that particular institution be consulted before plans are completed.

2. That the C.N.A. take whatever steps are possible to help the general membership become better informed regarding the nursing needs of psychiatric hospitals, more understanding of their problems, and more concerned with helping to find ways of solving those problems.

3. That the C.N.A., as an organization, indicate to the Mental Health Division of the Department of National Health and Welfare, to the Canadian Mental Health Association, and any other national groups that may be concerned with this problem, a readiness and a desire to cooperate in study of the problem of how to provide better nursing service for the patients in mental hospitals; and that the C.N.A. urge the provincial nursing associations that they take similar action on the provincial level.

The major responsibility of the nursing profession is to try to provide service commensurate in kind and quantity with the needs of the people it exists to serve.

Since mental illness seems to be on the increase and approximately 50 per cent of the hospitalized patients in this country are mentally ill, the basic preparation of nurses in all categories should place greater emphasis on psychiatric nursing so as to enable them to participate more effectively in both the preventive and therapeutic programs, and so fit them for first level positions in psychiatric nursing.

The specific recommendations presented in this report are directed toward measures which it is believed will help to accomplish that purpose. In the opinion of the committee, they are in line with C.N.A. "Policies Regarding Nursing Education."

References

1. C.N.A., "Report of the Special Committee to Study Auxiliary Nursing Personnel," 1952.

2. This refers to "The Proposed Curriculum for Schools of Nursing in Canada" published by the C.N.A. in 1936.

3. The term "patients under care" refers to the patients who were on the books of the hospital at the beginning of the year, whether in residence, on parole, in boarding homes, or otherwise absent, plus the total number of first admissions and readmissions during the year. (Dominion Bureau of Statistics, "Mental Institutions," 1951.)

4. For patients who require intensive treatment but who do not need hospitalization during both the day and the night, a day hospital has been found valuable. (W.H.O. Technical Report Series No. 73. "The Community Mental Hospital," Third Report of the Expert Committee on Mental Health, 1953).

5. "Facts of Mental Illness in Canada," 1953.

6. American Psychiatric Association,

"Standards for Psychiatric Hospitals and Clinics," 1952.

7. The Committee used the term "psychiatric nursing" in its broadest sense, i.e., to include both preventive and curative aspects of psychiatry.

Nursing the Mentally Ill

C. A. ROBERTS, M.D.

A FEW YEARS AGO, as superintendent of a mental hospital, I was too close to the problem of nursing the mentally ill — just as many nurses and physicians are today. Looking back on my hospital experience I realize that many of the recommendations made and decisions taken were greatly influenced by the pressures, well known to all of you, which exist in a hospital — shortage of staff, demand for additional bed accommodation and insufficient funds. The past three years with the federal mental health division have given me a more objective view.

Discussing the many mental health services with those responsible for their development and operation across this country, I have been impressed with the great efforts being made to improve conditions and overcome the many obstacles. It is my belief that real value can come from a free exchange of ideas and experience. Those responsible for various parts of the nursing program should meet frequently so that nursing education can be discussed by the educator who is responsible for the training and the hospital administrator who is responsible for providing the service. Sometimes I wish that we could hear the views of the patient—the consumer of these services! Too often when we talk of nursing education we have only the views of the nurse educator and, when we think of nursing service, only the views of the director of nursing service. Each has much to contribute to the other. The attempt to raise the standards of nursing education without a proportionate increase in trainees has tended to add to the difficulties of providing the adequate service to our patients which should be the object of both nursing education and nursing service.

Concerning our patients and our relationship with them, we are all aware that the health services are under frequent criticism from the public. We also know that individual members of this public, when they are ill, place a great value on these services and their attitude is quite different from when they are well and independent. To the sick person, the doctor and nurse have come to stand for security, the relief of suffering and the hope of recovery. The value of this association cannot be overestimated. It has accrued to us over the years as one of our greatest resources which we must never deplete.

There are many factors contributing to this status, such as the belief that the hospital, the doctor, the nurse and others stand ready to treat sick people without thought of race, creed, color or financial status. But, by the same token, the public has placed doctors and nurses in a special category above others in the community. As a result, much of the recent criticism has been related to the disillusionment and realization that we are only ordinary people subject to the same strengths and weaknesses as other individuals. Despite this, our patients still have a faith and trust in us which we must never fail to merit. We should always be humble in this thought and certainly never betray such trust for individual or group advantage. All of us in the health field have a great responsibility in this respect.

In spite of improved health education, the average person still looks on his body as a mystery whose complexity of design and function can only be

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understood by doctors, nurses and others with advanced education in the field. We professionals have become increasingly aware of the delicate interplay between mind and body. We now know that the individual function as a unit and that many illnesses have components of a psychological and physical nature. This has involved psychiatry, psychology, sociology and much discussion of interpersonal relations, etc. A great deal of jargon has been developed. All of us should realize the implications in these newer theories applied on either an individual or group basis.

Are we in our day-to-day activities able and willing to take into account personal motivation, family background and existing social pressures? Have we really developed a group approach to the care of our patients? Do we allay anxiety regarding anesthetics or electroshock, operations or insulin coma, enemas, rectal tubes, stomach tubes, transfusions and the numerous other procedures to which they are subjected? These are all routine procedures to us but do we stop to wonder how a patient feels about them? Many of us have been taught the need to allay anxiety. In practice I have many doubts as to our ability or real desire to apply this teaching. Yet it is well known that deep anxiety is normal in the face of the unknown and much of the early and uncomplicated anxiety seen in our patients can be relieved by an adequate explanation of the illness and treatment.

A medical friend recently told me that he learned more about patients' attitudes to their illnesses during his own recent serious illness than after many years of practice. He came to realize that procedures which are so routine to us professionally can be quite terrifying to us as patients. I recall a patient on the eye service in a large general hospital. I was asked to see him because he had become completely unmanageable. One eye had been removed and he was to lose the other as soon as his condition was satisfactory for the second operation. It took a considerable amount of sedative to control him and several days passed before my interviews were at all successful. Finally, however, I was able to establish contact with him and, with counselling, all of his anxieties and fears about blindness, cancer and even death were verbalized. After a further series of interviews I felt that he could undergo the operation. He did and in due course was turned over to the Canadian National Institute for the Blind for rehabilitation.

I cite these two cases to illustrate first, in the case of my medical friend, the great need for us to improve our attitude toward illness and treatment as seen, felt and interpreted by our patients; the second case because I do not think he should have required psychiatric care. The surgeon, obviously, was very busy and did not adequately discuss the patient's condition and future with him. The nurses either didn't recognize or did not report the increasing anxiety manifested by the patient and nothing was done until his condition became quite unmanageable.

I believe we have a responsibility to prevent emotional trauma wherever possible. We probably cannot be sure of preventing psychoses and many other such manifestations of maladjustment but we do know enough to reduce considerably the tensions experienced by most people during illness and crisis. There are still too many situations in which the recognition of emotional factors is by a process of elimination and even then the necessary overt action is left as a last resort. Human behavior is a positive activity; so is the sugar content of the blood or the presence of an infection. This behavior must be observed and deviations treated as early as possible — not after they have become chronic and fixed. It is quite obvious that doctors and nurses cannot experience the illness of their patients but, if they work closely with them in an attempt to establish sympathy, they can realize and appreciate more deeply the feelings and difficulties to be overcome.

We now believe that nurses should be taught to observe and report emotional manifestations beyond what is considered as a normal reaction to illness or surgery. In my contacts with

general hospitals and the training of registered nurses I am aware of the increasing emphasis on these factors in the training programs. Let me assure you that the mental health services and psychiatrists stand ready to help in this effort. Most of us believe that our role is to provide assistance in the training of registered nurses which is primarily the responsibility at present of the general hospitals or basic schools.

During the past several years our advisory Committee on Mental Health, through its Subcommittee on Training, has been giving increasing attention to the nursing situation in mental hospitals. We have deeply appreciated the cooperation received from the staff and executive of the Canadian Nurses' Association. We anticipate continued cooperation in the future.

How often do we attempt to understand the institutions which we call mental hospitals? What have been the historical influences on their present structure? What is their real purpose and how will they develop in the future? The patients in a mental hospital cannot be discharged if they are uncooperative. There is seldom an alternative hospital to which families can take the patient if they are dissatisfied with the care provided. In a general hospital if a patient becomes uncooperative, the hospital can request the patient to leave or ask the family to find accommodation elsewhere. In a mental hospital no matter how violent or disturbed a patient becomes, no matter how little he is able to appreciate and understand his treatment, he has to be cared for by staff.

Let me state definitely that the various types of hospitals in our country should be of equal status. It is true that lack of funds, overcrowding, shortage of staff and other factors have produced an undesirable and increasingly serious situation which is only slowly being understood and, unfortunately, corrected even more slowly. It will, and of this I have no doubt, continue to improve as the population at large becomes increasingly aware of the situation and of the needs which must be met if the large numbers of mentally ill are to receive adequate care.

The mental hospitals must provide care for all mentally ill persons whether suffering from tuberculosis, infectious diseases or other conditions; whether they have been involved in crime or other activities necessitating their admission. The wide variety of illnesses and patients to be cared for has been gradually recognized with the result that our mental hospitals are now developing admission units, medical-surgical services, tuberculosis units, geriatric centres, continuous care programs and many other special services. To serve these patients and their various needs adequately we must provide clinical and pathological laboratories, x-ray, operating rooms, B.M.R., E.C.G., E.E.G., etc. These will be as high in quality as those in general hospitals. In addition it is necessary to have all of the facilities required for the psychosocial treatment of the mentally ill — individual and group psychotherapy, occupational therapy, work therapy, psychodrama, recreational therapy, psychology, social work, etc.

To do this adequately we are finding that more and more staff of all types is required — physicians, nurses, technicians, occupational therapists, psychologists, social workers, etc. In 1950 there were 4.1 patients to each employee in our mental hospitals; in 1952 this was 3.7, or an increase of 10% in staff ratio during two years. There is no indication that we are yet near the optimal staff-patient ratio. In 1952 there were 8,963 nursing personnel employed in mental hospitals giving a ratio of 1 to 6.4 patients. The total of 8,963 was made up of 1,007 registered nurses, 1,470 other graduates and 592 students; 5,895 were classed as aides and attendants. Of the estimated 43,380 registered nurses in Canada in 1952 only 1,007 or 2.3% were employed in mental hospitals. In the face of this there were more patients in our mental hospitals than in public general hospitals.

The traditional approach to mental hospital nursing has been that recommended by the American Psychiatric Association as follows:

1 Registered nurse to 6 acute patients

and 1 to 40 continuous care.

1 attendant or aide to 4 patients.

If we apply this formula to our mental hospitals we would require about 9,603 registered nurses and 14,405 aides and attendants. The recruiting of an additional 8,000 registered nurses would be a most formidable task for the mental health services, as would the training of 14,000 aides and attendants. Even if the APA standards were met there is a growing feeling that this pattern of staffing would not meet the needs of our mental hospitals. It is now suggested that psychiatric nursing is inherently different from general nursing. Because of this it is felt that the three months' affiliation or psychiatric experience being provided, while doing much to improve the care of patients in general hospitals, will still fall far short of adequately training nurses for the mental hospitals.

The basic training of a registered nurse and the orientation of the general hospital is to care for physical illness with psychiatric care emphasized only to the point necessary to care for the patient suffering from physical illness. It is true that the introduction of psychiatric units in general hospitals is broadening this horizon somewhat but even here the emphasis is on persons with neuroses and psychosomatic conditions — or, if you like, persons with physical complaints due to the existence of unsolved emotional conflicts. A few depressions, anxieties, etc., may be cared for here but these units should not divert their energies from their primary function which is to care for those patients who are compatible with general hospital care. Other more chronic and more disturbed patients — those not compatible with general hospital care — should be admitted to special psychiatric hospitals and mental hospitals.

Psychiatric units in general hospitals should not and will not replace the mental hospitals; they are complementary to them. Even these units will require nurses especially prepared in psychiatric nursing and will have to have psychiatric services such as psychology, social work, occupational and socialization therapy beyond that normally found in general hospitals. The nursing supervisor of the psychiatric unit should be responsible for the nursing service of the unit and should be used throughout the hospital to assist other members of the nursing staff to understand and care for the emotional needs of patients.

It is my belief that the care of psychiatric patients in mental hospitals is primarily in the psycho-social area with secondary interest in the physical conditions. Adequate services with competent staffs are being provided for the physical illnesses. Here, however, is the converse of the situation in a general hospital. It is held by many that the bulk of the nursing staff requires minimal training in the physical side of nursing but better training in psychiatry, psychology, social work, occupational and recreational activities, etc. It is true that all of this can be added to the training of a registered nurse, but it will take an additional 12-18 months. At the same time it is questionable if the nurse for the mental hospital requires all of the other training given to a registered nurse. In a mental hospital the training and experience of a registered nurse is necessary in the care of the physically ill, tuberculosis cases, the operating rooms and other special areas. It has also been suggested that a strategic use of the registered, supplemented by nursing assistants, will do. It is certainly not possible for certified nursing assistants with a few extra months of psychiatric experience to meet the need. It seems to many of us that a clear case exists for the training of a new professional nurse — the psychiatric nurse — this professional person to have sufficient training in physical nursing for the need, but in the main to be responsible for the psychiatric nursing care of psychiatric patients.

The heart of the matter is the recognition of the essential difference between a mental hospital and a general hospital. The former is primarily concerned with emotional illness but provides necessary treatment for physical illness; the latter with physical illness but also caring for the emotional illnesses of its patients. If we are to

develop a new approach to nursing staff in mental hospitals this difference must be clearly recognized. This new professional worker would not be superior or inferior to the registered nurse, or vice versa, but each would have equal competence in her own particular field of nursing. One hopes that mutually satisfactory programs can be developed — satisfactory to the mental hospitals and to the various nursing groups. But, of paramount importance, *adequate nursing services for the mentally ill must be provided*. In Great Britain, separate programs existed for many years but recently there has been a forward step in a common examination at 18 months followed by specialty training. Perhaps it is too much to hope that we might benefit from their experience. One might wish, however, that a satisfactory solution could be found which would allow for considerable common training and the opportunity to specialize in one or more fields as the student desired.

About administration of nursing services in a mental hospital, there is considerable difference of opinion at the present time. Most psychiatrists seem to agree that a unified nursing service is desirable and that a single standard of nursing service should apply throughout a mental hospital. There are reasons to believe that such unification cannot be developed successfully at the present time. Male registered nurses are almost nonexistent; experienced attendants and aides resent supervision by either doctors or nurses who are not qualified by experience or training for the job of supervision. If a system of double qualification could be developed it would be possible to provide proper job classifications. With clear definition of role and responsibilities, many of the present difficulties in developing an adequate unified nursing service would be overcome. One can visualize that many positions in a mental hospital would require double qualifications, e.g., director of nursing service, director of nursing education. Many positions would require registered nurses — operating room, medical-surgical service, etc. The great bulk, however, would require only psychiatric nurse qualifications. In the general hospitals, at least one position, supervisor of the psychiatric unit, would require double qualification.

SUMMARY

1. We have realized that the individual, whether sick or well, functions as a unit with changes in either mind or body causing changes in the other, and that in the care of what appears to be physical illnesses, we must be aware of the emotional factors. In the training of registered nurses, increased emphasis is being placed on this and we can look forward to improved treatment of the patients in general hospitals.

2. While the psychiatric units in general hospitals will broaden the horizon of service, these units cannot be regarded as replacements for the mental hospitals.

3. There are certain basic differences between a mental and general hospital. This had led to a suggestion that it might be wise to consider the preparation of a special worker, the psychiatric nurse, for a large part of the nursing service in mental hospitals. In order to bring about proper coordination of nursing services, it might be well for a considerable number of nurses in mental hospitals and a smaller number in general hospitals to be doubly qualified.

I have not taken time to develop the role of industrial and public health nurses in an adequate mental health program. It does appear, however, that they both will assume a more important role as efforts to prevent emotional illnesses are increased. Both of these specialized nurses should have sufficient training to enable them to appreciate and, indeed, handle what can be thought of as normal responses to stressful situations. In addition, they should be able to recognize abnormal conditions and be capable of realizing the difference between a normal and abnormal reaction so that a referral can be made for the necessary psychiatric treatment.

There is no need for anxiety regarding the points I have raised, but there is certainly need for solemn and serious thought. The cooperation of registered nurses in mental health activities has been much appreciated everywhere and

we hope it will continue. Finally, may I state again that I believe a new approach to nursing in mental hospitals is necessary. I have suggested one approach that is already being tried in some areas — perhaps there are other and better methods that can be investigated. I hope that the nursing profession will see fit to support and encourage the initiation of some of these new approaches to the nursing care of mentally ill persons.

Providing Nursing Service for the Mentally Ill

ELIZABETH BREGG

THE OPERATION OF A HOSPITAL involves many complicated services if the goal of therapeutic care for patients is to be reached. The standard of the care desired and maintained is the result of vision, vigilance and research on the part of all those concerned in the production. This necessarily includes all hospital personnel and in the main is dependent upon the leadership provided. In terms of nursing service, the greatest problems have been to find the leaders, to ensure them the freedom in which to work and to develop paths of communication by which this ideal of service may be extended to all those in direct contact with patients.

In itself this is complicated and sometimes seemingly impossible but when we add to it, as we have done in psychiatric nursing, a new concept and new techniques, diametrically opposed in some instances to the traditional and custodially oriented picture of the past, then the path becomes tortuous and involved.

This newer or changed approach to psychiatric nursing has been evolving slowly for many years and is, of course, still within the period of transition so that our views of yesterday, while influencing the views of today, may be compatible in only minor ways with our views of tomorrow. While we must secure the sound and proven from the past as foundation, it becomes increasingly difficult to sort this from our own prejudice and to clear within ourselves and our institutions an open pathway for the new.

Psychiatric nursing has emerged as an area of nursing requiring special professional preparation with specially defined skills. No longer can we be content merely to observe and report accurately for someone else's use, presumably the psychiatrist, those changes or modes of behavior demonstrated by patients but we must be ready to interpret what we see, to validate these interpretations and to use this knowledge therapeutically for the patient. So the nurse becomes not the handmaiden but a professional nurse practitioner working with other disciplines as a contributor.

To some of this we have long paid lip-service and our status needs have driven us, often aggressively, to assume roles for which we were not prepared. The day of dreaming is past and now is the time to make the dream come true. This new approach or preparation for the most skilled branch of nursing comes slowly and spreads slowly. It meets with active and passive resistance. To establish a relationship which is therapeutic requires on the part of the nurse an awareness of her own modes of operating, a willingness to study the operations of others and the ability to deal with these revelations frankly and freely. The freedom to do so arouses threat, conflict and anxiety to herself and to others. We must be able to realize that not all people wish this freedom but will flee from it to the safer and less exacting limits of authorization control. The issue then rests on whether we want a

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nursing service dependent on percipient, inquiring people or whether we shall continue to accept controls exercised from above and evaded and resented from below.

With this viewpoint as our guide in considering the major problems in providing nursing service the solution, and indeed, the nature of the problems become not less acute but more hopeful.

It would seem that the most pressing of all problems in providing nursing service is the lack of nurses interested, prepared or motivated to work with the mentally ill. Many reasons for this have been given over the years, some valid, some bitter and some unrealistic. There is no one answer to the difficulty. We tried to solve it by establishing basic schools of nursing in the mental hospitals. These have in many cases perished through inability on the part of the school to meet changing educational outlooks which did not countenance schools in special hospitals and through failure on the part of such schools to supply, through their graduates, adequate staff returns to justify the costs.

We tried to solve the problem of staff by the establishment of affiliation centres in the mental hospitals. To date, and speaking personally, this solution is not meeting with the success we envisioned. We have established in various universities courses in clinical supervision in psychiatric nursing to prepare teachers and supervisors for the educational programs in mental hospitals. These programs are successful in increasing the number of teachers but are failing in many cases because of the quality of the individuals applying and accepted for these advanced programs. The problem is, therefore, deeper and more fundamental and it is in this area that nursing research is vitally and urgently needed. Shall we continue to countenance our failures or bestir ourselves to test and organize change within our professional and educational rights? And, shall we attend to this before some other group undertakes it for us?

It is always a tenet of sound education to start where the learner is. This, in terms of inservice programs, would give us the impetus and the source for our changes. How do we begin to work with entrenched personnel so that existing conditions are analyzed, evaluated and remodeled? Why will nurses continue to work for years in institutions where the standard of patient care does not meet in any way a decent standard of living?

There are mental hospitals, and of course general hospitals too, where the nurse is constantly frustrated because of lack of work equipment — not expensive and comfort-giving equipment but such small things as face cloths or dishes or cleaning materials. Day after day they serve unappealing trays or herd large numbers of our citizens into bare and distasteful dining halls. They go on duty to overcrowded, badly ventilated wards. They distribute drab institutional clothing, spend hours making requisition lists, counting patients, sorting linen. They may work for years with only minor satisfaction held by pension funds, by the relative comfort of drugging routine and by the inertia which smothers initiative. Loyalty should not become synonymous with martyrdom and too frequently this has happened.

Can we restore or give to these valued staff members job satisfaction of which to date many of them have never dreamed? I think it can be done. It will cost governments money but surely if the cost of hospitalization for almost 50 per cent of all patients in Canada was brought only partially in line with today's cost of living each mental hospital would find its income tripled. Can we make these staff people actually members of the treatment plan? We have attested verbally to this for a long time — now is the time to put it to practise. Should we begin studies of the social workings of the ward with the nurse and her relationships viewed as a vital and constructive force? Shall we help the nurse to study her own modes of operating so that we can clearly see the strengths and weaknesses of her interactions? We can't do this without drawing in the psychiatrist — and it may well be that here we meet our Waterloo temporarily.

In an area of medicine as vague as psychiatry, where each clinician may become a powerful but beneficent tyrant, this forcing of sharing and colleagueship can be an overwhelming threat. It can be threatening also to the nursing service hierarchy and requires for its success a degree of safety and maturity on the part of these people not easily attained. An inservice program devoted to a reserving of the old textbook views on descriptive psychiatry has made and will make no headway. On the other hand, a departure into an examination of meaningful relationships and an evaluation of these relationships in terms of their therapeutic achievement will yield positive results.

It seems essential to this plan to study our goals of therapy as they relate to nurse satisfaction. In nursing generally we are almost obsessed with the need to cure our patients. Death is interpreted as failure. In psychiatric nursing, the goal of care becomes necessarily much extended. We know from psychology that as maturity develops so does one's ability to postpone satisfaction and to establish long-term goals. As we become able to determine and spell out the goal-directed nature of nursing we can make our day by day nursing plan a learning experience for the patient and the nurse. The greatest possible satisfaction will be the nurse's when she recognizes and responds knowingly to the cues received from her patients. The testing and validation of these cues with other workers and eventually with the patient will lead to a growth and development for both the patient and the nurse. This ensures the nurse's role in therapy as a vital moving force in the direction of health and it provides the milieu for personal development on the part of the nurse.

While it is no doubt possible for a nurse to carry this kind of nursing out alone, it is certainly less anxiety-producing if her plans, struggles, successes and failures are shared. Ideally this sharing or communication extends up and down or out in all directions. The strength each nurse needs can come from her nursing service supervisors and directors. She needs to be free to disagree, challenge or suggest alternatives to policies and dictums. Such freedom must come from above and extend to all below. There must be no use of recrimination or judgment. I am not, of course, negating the necessity of practices instituted to protect patients both physically and psychologically. The nurse who uses the patient to meet her own pathological needs for power, dominance and love is well known to us all. The supervisor while creating freedom for growth must restrict the use of freedom for such malpractice.

Once the nurse is able to accept her role as identifier and interpreter of patient needs then she must be strong enough to voice her opinions of these, backed by her observations and not by her personal prejudice and bias to other disciplines. We have a long history of compliance and backwardness of a self-deprecatory nature to overcome. It can be overcome only when we make clear our special skills and when our "good" nurses operate not intuitively but knowingly as specialists in their field.

While I believe job satisfaction to be the primary answer to our greatest problem, which is assuredly nursing shortage, it is not the only answer. Nurses need to live comfortably off duty as they choose to live. Money is an essential in our civilization. Now we meet, but barely, the salary scales essential to a satisfactory standard of living. When we supply residence accommodation we do it economically and in a boarding school environment. It would not be unreasonable to expect that these women might like to cook or garden or sew or live without supervision. If this is fanciful then our salaries ought to cover living accommodation outside of the hospital where such activities could be carried out. We are fond of reiterating that these are professional people but the money commensurate to the purchasing of books, attendance at conventions or the driving of a car is not forthcoming. In the hierarchy of hospital life the nurse comes relatively far down on the scale and none will dispute the fact

that status needs are important. If the nurse is seen importantly in her right as a citizen, an educated woman and a member of the therapeutic team, we could, to a degree, relieve dissatisfaction and promote health and stability.

I have obviously touched only the major problem in providing psychiatric nursing as I have seen it. Approached administratively there are others which at times become more frustrating and more limiting. The nursing department in the mental hospital headed up by an able woman is rarely allowed any independence of thought or action. Her decisions must be offered to the medical superintendent for ratification — this in matters that he is not prepared to meet either by vocation or training. Fortunately some of us are not so limited and we are, I think, those from the progressive centres. But the old pattern persists insidiously. Often the nursing department has no measure of supervision over the nursing care of male patients and in such instances those wards cannot be used for teaching programs. Not infrequently, the chief attendant or aide is as highly paid as the director of nurses — an attendant by virtue of tenacity, better paid than the instructor and the chief gardener more highly paid than all!

Too often too, the nursing staff is not welcome at conferences or policy-making meetings. Seldom is a nurse consulted in building or expansion plans. Such oversights cannot be said to be unintentional because they are so frequent. To the director of nursing it must often seem that she is only essential when the numbers of staff nurses she is supposed to produce fail to materialize. Again this is in part due to our failure to insist on recognition as specialists and in part to the transgression on the part of the psychiatrist of areas responsible to him but not autocratically his. For optimum function a proper balance of freedom is essential, determined by the capacity of the individual to handle it at any particular time.

As we all know from sad experience there is no quick remedy to the desperate situation prevailing in our mental hospitals nor is there a short-cut to the cure. The tremendous complication of the newly arrived "psychiatric nurse" operating outside the organized profession is obvious. As a stop-gap her immediate success is seen but in terms of what the procedure has done to the future status of these people and to the future development of psychiatric nursing as a specialized, highly skilled branch of nursing the move is little short of disastrous. If we can, by compromise and modification of the existing schools, draw them within the organization we shall have strengthened them immeasurably and added to our strength as a representative national nursing organization.

To prepare nurses in mental hospitals for this broader, more satisfying therapeutic care of patients we must turn to our universities and to financial support from governments. The new yeast cannot ferment all the bottles at once. One person in each province to spearhead the attack will not be difficult to achieve and if, as an organized nursing association, we support each of these people the task is well within the realm of possibility. For nursing research the setting aside of one patient in a ward, one ward in a hospital, one hospital in a system would give us the statistical ammunition we so sadly lack. Psychiatric nursing is a science of knowing human nature. Once such satisfaction is experienced the nurse can no longer be satisfied with the bare framework of technical skill.

In conclusion, let us be certain of one thing: the special skills of the psychiatric nurse are not custodial but therapeutic. The Greek derivation of this word gives us the meaning "to minister to," "to serve," "to give aid." It broadens our horizons from solely the care of patients to staff ministrations and service to the community. Our beginnings in the task are not the foundation of new schools or systems of schools but the development of those people already employed in the care of the mentally ill so that the climate becomes healthful and educational. Toynbee in "A Study of History" defines society as a system of relations be-

tween individuals, a field of action common to a number of human beings. Psychiatric nursing is that very same thing — a system of relations between individuals, a field of action common to a number of human beings.

Psychiatric Nursing in the Wards

EVALINE BROWN

PATIENTS, and therefore the public generally, have a right to expect high standards of practice and conduct from professional nurses. Public regard depends upon the behavior of the average graduate nurse, so each nurse must make it her aim to develop professional standards. The kind of nurse needed in all parts of the world is one who is prepared, through general and professional education within her social structure, to share as a member of the health team in the care of the sick, the prevention of disease, and the promotion of health.

Nurses today are becoming increasingly aware that the patient must be regarded as an integrated unit — a whole person, reacting with his illness or health, his body, his mind and his emotions in unison. He has a set of values, dreams, ideals, wants and needs. All these are part and parcel of his illness. We can no longer nurse the illness alone — we must nurse the person.

THE PATIENT AS A PERSON

In order to illustrate this concept let us focus our attention on two average nursing situations:

Mrs. Grant was in bed No. 3 on Ward F. When a new nurse reported for duty on this ward she was informed by other staff nurses "to avoid Mrs. Grant and not to spoil her. She's just neurotic and selfish and demands attention she does not need!" This type of patient was not new to the nurse — she had encountered others during her experience in psychiatric nursing. Because of her background she asked why Mrs. Grant was the way she appeared and what were her physical complaints? On looking into her history the nurse learned that Mrs. Grant had been admitted to the hospital following a "suicidal jump from a fire escape, and had suffered 32 fractures." After exhausting her financial resources on a private room and three private duty nurses, she was reduced to the status of a "staff" patient in the public ward. The fractures were healed, but Mrs. Grant appeared quite helpless and suffered considerable pain. Obviously she was still suffering from the depression that had driven her to her "suicidal act." This depression (her real illness) was being entirely overlooked in the daily hospital care.

As the days progressed the nurse found Mrs. Grant extremely demanding of her time and attention. She could readily understand why the other nurses avoided her. They had "so much to accomplish in a certain time that there were no spare moments for Mrs. Grant — she doesn't need all that attention anyway!" The nurse, with her background in psychiatric nursing, realized that her nursing problem was a personal one. In order to understand Mrs. Grant's behavior she must first learn to understand her own feelings in relation to Mrs. Grant — that she must adjust to Mrs. Grant; that Mrs. Grant had been unable to adjust to her illness. The nurse realized that Mrs. Grant was trying to convey something to the staff — that her behavior needed to be accepted by the nurses.

Realizing these important factors in relation to Mrs. Grant, the nurse was able to reach a personal solution to her problem in nursing her patient. She developed unlimited patience with Mrs. Grant — not only did she appear patient, she actually felt patient! As a result of

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this, good rapport was established. Mrs. Grant learned to trust her nurse as the various nursing procedures essential to her hysical needs were performed. During her care Mrs. Grant learned that she could talk to her nurse. Just the airing of her problems seemed to afford her much relief; she revealed much of herself and of her troubled mind. Her physical pain was lessened, she spent less time demanding. Little by little, in encouraging her to talk, the nurse learned her patient's history. She was forced to marry at 12, had a family of six children at the age of 23, a drunken husband and no financial security. She stated that "things piled up so high that I became depressed and decided to end it all!"

At this point in the nursing of Mrs. Grant, the nurse became aware that she was no longer avoiding her patient; that she was gaining much knowledge and personal satisfaction from Mrs. Grant. She learned that she was helping Mrs. Grant where she most needed help and support. Mrs. Grant was admitting that to talk over her troubles with a sympathetic listener was all she needed. She developed little tricks to gain the nurse's attention such as asking for an unneeded bedpan before her nurse went off duty — just so that she would be the last patient to receive her nurse's attention that day!

After several weeks of this new form of understanding care, Mrs. Grant laughed! It was a reluctant laugh at first, but nevertheless a laugh. How rewarded the nurse felt! Even conversation was carried on in a lighter vein. Mrs. Grant became a much more pleasant patient. She progressed so far along the road to recovery that the other nurses no longer found themselves avoiding her!

For the second example let us take Betty's case.

Betty was admitted to hospital with a diagnosis of "severe shock and possible ruptured appendix." An immediate appendectomy was performed and Betty made a surprisingly good post-operative recovery. She had been placed in a public ward in the bed next to a 16-year-old patient. These two girls became very friendly. They laughed and chattered most of the day, were popular as patients with the nursing staff. One morning a senior student came into the office to report that "Betty seemed much different today. She had hardly said a word to anyone, has no interest in her food. I have checked her temperature and pulse and they are normal. She says she feels alright but I think she has been crying. What should I do?" What had happened to Betty?

The head nurse realized there are individuals of any age who are insecure, who obtain much personal satisfaction in attracting and getting special attention. Was this the case with Betty? The head nurse also realized that the adolescent does not like to be different from the group, nor to be singled out and made aware of differences in herself. Had anyone in the ward said anything to make Betty feel different and therefore isolated from the others? What could be troubling her today? The head nurse began to inquire of her staff just what had been done for or said to Betty. In the course of these inquiries she found that while the doctor had been changing Betty's dressing he had commented to the nurse in attendance that a patient he had examined previously "would require more surgery." Betty thought the reference was to her. Neither the doctor nor the nurse had noticed Betty's sudden reaction of fear and anxiety.

Let us review the case problem of Mrs. Grant. She had received the nursing care and treatments indicated for her particular illness but was obviously not responding well. The staff in "avoiding her" revealed a serious lack of understanding due to this gap in their preparation and experience. They were unaware of her emotional conflicts and of the mental trauma she had suffered. The nurse with previous experience in psychiatric nursing was enjoying her daily contacts with Mrs. Grant. Why? The answer lies in the broader background of her experience. She had developed the understanding necessary to give *total* care to her patient. The nurse had become an attentive listener, had developed a sympathetic interest and alert awareness to all factors that seemed to influence the course of Mrs. Grant's illness and behavior. In other words she was nursing the *whole* patient.

In considering Betty, an endeavor has been made to point out how the nurse must learn to become sensitive to the fact that people react to her words or actions. How important it is to avoid producing unnecessary anxiety! We must never forget that patients have ears; that what we may say can be misconstrued by them, producing all manner of changes in their behavior — fear, sullenness, apathy, elevation in temperature, loss of appetite, disinterest, and so on. In this instance Betty thought she was to have further surgery and she was afraid! She was unable to voice her fear but she was telling the student nurse by her change in behavior what she could not verbalize. How astute of this student to recognize this change of behavior! More remarkable still that she asked "What should I do for Betty?" This very question points out the need for psychiatric nursing instruction and interpretation. Nurses need to be taught how patients, by the very nature of their general behavior, express their innermost needs. They must be trained to see, to understand and to take measures to meet these needs.

Nursing is a human relationship between an individual who is sick or in need of health services and a nurse specially educated to recognize and respond to the need for help. Much personal satisfaction is to be gained by nursing the Mrs. Grants of this world; for by helping patients to identify personal troubles in their current situation and to discover and understand what is happening to them during their illness, the nurse both expands her own insight, knowledge and understanding and helps the patient to grow.

The Assistant in Psychiatric Nursing

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THE ACCEPTED DEFINITION of a nursing assistant describes her as:

> A person trained to care for selected convalescent, subacutely and chronically ill patients, and to assist the professional nurse in a team relationship, especially in the care of those more acutely ill. She provides nursing service in institutions, and in private homes where she is prepared to give household assistance when necessary. She may be employed by a private individual, a hospital or a health agency. She works only under the direct orders of a licensed physician or the supervision of a registered professional nurse.

This definition indicates that the nursing assistant is a person trained to care for patients. In other words both are people. We know there are basic human needs for every person, irrespective of age, ability or social status. Therefore, it follows there are basic human needs which must be met both for the nursing assistant and the patient if we are to fulfill the purpose of nursing.

The limitation of the nursing assistant is in function and education only. There is no limitation on the development of understanding, motivation and interpersonnel relationships within her own sphere nor on her progress toward optimum individual maturity. We are all in constant interaction with other people. The way in which we react to them will depend upon the degree to which our two basic emotional needs — belonging and security — have been met in the past. Where there is some limitation in education or function, there is less learning through mistakes which needs abstract thinking and more learning through achievement.

As our learning response and our behavior are largely influenced by our emotions it stands to reason that the educational program for the nursing assistant must be designed to meet her needs. It must provide learning situa-

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tions within the realm of her capabilities which will enable her to develop an understanding of both herself and the patient, as well as develop technical skills. Unless this understanding is developed, nursing will be performed for and not with the patient. The learning situations must also fill her need to feel that her work is important to an individual patient.

The registered nurse who assigns work realistically, taking into consideration the patient's needs and the capabilities of the nursing assistant, will create a setting in which the nursing assistant develops satisfaction and skill in her work. She will feel she is essential to the well being of each individual patient.

The nursing assistant needs to have a basic understanding of the stages of human development, the effect of environment on behavior and to appreciate that the patient is liable to regress or to deviate from normal behavior when under stress and strain of illness. One nursing assistant who had developed this understanding, cheerfully changed a boy's wet bed and while talking to him found that he thought visiting hours were over as his roommate's mother had come and gone. Through her sympathetic understanding she was able to discover the boy's fear and set his mind at rest. Had she been preoccupied by a feeling of irritation at the boy for wetting his bed, she would undoubtedly have failed to get his confidence. Besides adding to the well being of the lad, she augmented her own feeling of security and "job satisfaction."

How can these learning situations be incorporated into the nursing assistants' curriculum and program of studies? The curriculum should be based on patient centred situations. For example, the patient who needs an enema presents many learning opportunities. The emotional reaction may differ only in degree for rational and irrational patients. The essentials of personal hygiene are common to both — modification of diet, adequate fluid intake, exercise, the ability to relax, manipulation of the environment to suit the individual.

The patient's viewpoint approach can best be understood by the person who has had experience as a patient. For most students this experience will have to be contrived. It may not be possible to put each student on absolute bed-rest for 24 hours as suggested by Mary Ruth Ubbink in the *Nursing Outlook* for April 1954, but it is possible for each student to obtain some firsthand knowledge of what it feels like to be a patient. Each can receive a bed bath, be fed a meal or at least receive a drink when flat on her back.

It is the nursing assistant who, not responsible for organizational and administrative duties, spends the major part of her time actually working with the patient, particularly with the convalescent patient and the one with a long-term illness. It is she who performs the greater portion of personal nursing care. The rehabilitation of the patient is a continuous process, commencing at the first indication of illness and not completed until he achieves individual optimum health. How can he obtain this goal if the nursing assistant, who spends so much time with him, is insensible to his needs and unable to follow directives regarding the prescribed therapy?

The success of the patient viewpoint approach depends upon the personality of the teacher and the teaching skills which she employs in both planned and incidental teaching. In the clinical situation, interpersonnel relationships, the correlation of classroom skills and knowledge obtained by the nursing assistant student will depend to a great extent both upon the quality of the clinical supervision and upon the nursing care performed by other members of the team. Ask a nursing assistant why she does a certain thing and 99 times out of 100 the answer is, "Miss R.N. does that so I thought it was all right if I did it too."

The majority of nursing assistant students have to make many personal adjustments within themselves during their program of studies. Therefore, it seems advisable that they should develop good basic nursing care skills before having to adjust to patients with gross personality disorders. They

should learn to give nursing care to the "average" patient, who probably has a mild personality disorder, before being assigned to the patient suffering from a gross personality disorder.

It appears that a basic generalized pr ram, plus orientation and in-service education would result in improved nursing care. The better the nursing care the sooner the patient returns to normal living. The policies regarding nursing education published by the Canadian Nurses' Association suggest that the basic preparation for nursing assistants as well as for registered nurses shall be generalized rather than specialized.

This seems logical. Certain areas require high development of specific knowledge. No one person can be a specialist in all areas. The interchange of ideas brought by nurses who have knowledge of the latest development in all areas should make a valuable contribution towards improving nursing care. Effective psychiatric care is required in general hospitals, both on disturbed wards and for all patients. In the same way, a high degree of nursing skill is required for patients who are ill with tuberculosis, diabetes, etc., in the mental hospitals. Should not our goal be a "community" hospital, non-specialized, accepting all patients?

As the registered nurses' jobs change so the nursing assistants' jobs change. Just as the registered nurse program broadens out to meet all the social, physical and emotional needs of the patient, so the nursing assistants' program must reach in to touch and overlap or there will be gaps in total nursing care. If the nursing team is to function effectively there must be consistent thinking among all members.

The criteria set up for evaluating the program should be reviewed periodically. Evaluation and appraisal of the program, both pre-clinical and clinical, must be continuous. Do the instructors and clinical supervisors have the preparation and help they need to enable them to obtain job satisfaction as well as provide for the learning, counselling and guidance of the student nursing assistants? Why is the rate of student withdrawal higher in some schools than in others? In Manitoba this is highest from the mental hospital schools. The real test of the program is the effective performance of the nursing assistant after she has graduated and is certified or licensed. All criticisms, adverse or complimentary, should be appraised carefully so that needed revisions in practices and aims may be identified, and better learning situations created through clarification of goals. The evaluation must provide information as to the degree to which the purpose of the program are being achieved. How do we know which program is most effective unless we have comparative programs?

We talk and read about the newer concepts of nursing and nursing programs. Are not the purposes of nursing the same as those stated so long ago by Florence Nightingale? The objectives in the training of nursing assistants have not changed from those given for trained attendants by Dr. C. B. Burr at the International Congress of Charities in Chicago in 1893.

1. The stimulation of discriminating ability.
2. The development of perceptive and reflective facilities.
3. The recognition and understanding of the patient as an individual person.
4. The development of adaptability and resourcefulness.
5. The development of tolerance for the patient's idiosyncracies.
6. The gaining of an understanding of the nature of mental illness, the cause, symptoms and treatment.
7. The development of skills in nursing arts.
8. The achievement of a sense of the worthwhileness of the work.

To meet these objectives the nursing assistant's program must prepare her to understand the patient as a person, to recognize deviations from normal health and personality changes, and give her the satisfaction of knowing she has a valuable contribution to make to nursing care.

A tart temper never mellows with age; a sharp tongue is the only edged tool that grows keener and sharper with constant use.

— WASHINGTON IRVING

Allan Memorial Institute of Psychiatry

JEAN G. TURNER

THE BRIGHT LIGHT that pours in the wide windows of the new wing of the Allan Memorial Institute of Psychiatry gives the pastel painted rooms and broad halls a look of sparkling vitality. It also throws fresh, clear light on the tremendous strides that have been taken in recent years in the care of the mentally ill.

Unique in Canada, the Allan Memorial Institute, as a department of the Royal Victoria Hospital, Montreal, offers hospital clinical services for resident and ambulant patients. Additionally, as one of the centres of the Department of Psychiatry of McGill University, it conducts an extensive program of research and provides training for psychiatrists, medical students and nurses. Already this linking together of facilities has proven its value and attracted world-wide attention.

To this most modern of hospitals, patients are admitted on exactly the same basis as they are to any other part of the Royal Victoria Hospital. They are admitted only if they wish to come; they stay only if they wish to stay. There are no locked doors or barred windows. Rather, there is the cheerful atmosphere of a residential hotel because the building is designed on the premise that the treatment for the patient suffering from emotional problems is primarily his doctor's office and the rooms where he has group or occupational therapy not just the bed, as is the case with a patient suffering from pneumonia or a heart condition.

Folding back the dividing wall.

Single rooms predominate and there is no accommodation larger than a four-bed room. However, on the suggestion of the Institute's supervisor of nurses, the two four-bed rooms on each ward which are used for insulin coma therapy were constructed with a dividing wall that can be folded back thus enabling one nurse to care for eight beds.

Each room has its own toilet facilities. The furnishings match the modern decor — low beds with attractive spreads, chests of drawers and desks in light-toned woods, a comfortable lounge chair with footstool and adjustable reading lights in each room and gaily patterned curtains at the windows. There are patients' libraries on each floor and a telephone system for their use. Each ward has a lounge where radio and television may be enjoyed and a games room which, at meal times, becomes a dining room, the tables immaculate with white cloths, silver, china and glass. The living area, moreover, opens out on to spacious grounds on the slopes of Mount Royal.

There is a service kitchen on each floor where the meals and all special diets prepared in the large, modern kitchen on the ground floor, are brought on electrically heated trolleys. The nurses' office, the supply and preparation rooms, and the rooms where the medical students work at their case records, are equipped in the most modern manner. The nurses' offices are connected by an electrical system with the treatment rooms and also with the central dictating pool. The physicians on their rounds may dictate their observations and orders directly to the central pool where they are transcribed by the secretaries and placed in the permanent record of the patient. There are laundry and incinerator chutes from all patient floors. Leading directly from the wards are the corridors containing

the doctors' offices so the patients walk but a few steps to their appointments. The housekeeping offices and the offices of the central nursing administration are also located on these floors in order to facilitate supervision of nursing service.

While the housing of the patients is of primary importance at the Allan, its place as one of the great teaching institutions of the world has not been overlooked. Certain of the treatment areas contain one-way screens in order that treatment methods can be demonstrated — always with the consent of the patient — to the psychiatrists-in-training without interfering with the procedure. Other treatment areas are wired for a closed circuit television system which extends to the teaching rooms on the ground floor so that the new methods in psychotherapeutic and chemical treatments can be demonstrated to large groups of doctors, nurses and students.

It is a startling fact that while today 50 per cent of all hospital beds are occupied by mentally ill, only 3 per cent of the nurses have received the specialized training required to care for these patients by modern methods. In order to help bridge this gap, a six month's post-graduate course leading to a certificate in psychiatric nursing has been launched at the Allan. For the first three months a living-out allowance is paid the nurses on course; for the final three months they receive the standard general duty rate of pay. Too much emphasis cannot be placed on the great need for graduate nurses trained in the psychiatric field, yet, at the same time, stress must be laid on the fact that somewhat different qualities are required in a psychiatric nurse than are needed, for example, in a good surgical nurse. To be a good psychiatric nurse, the graduate must have a great interest in people, not just as patients but as human beings. Even when her hands are not busy she must maintain her contact with her patients by being always friendly, approachable, sympathetic. She must never lose sight of the fact that to the mentally ill she is the link with the outside world. A good psychiatric nurse can be of enormous

Informal round-table discussion.

assistance in building up the confidence of the patients, in making them feel acceptable once again. She must give so much of herself that while she may not be physically tired, she does become mentally fatigued. There is a definite strain in being always sympathetic yet never becoming too emotionally involved. But the strain and fatigue are forgotten when she sees one of her charges going out to resume his rightful place in the world.

In addition to the graduate nurses who study at the Institute, approximately half of the student nurses from the Royal Victoria Hospital have been receiving experience in the Allan. With the larger facilities now available, it is hoped that all student nurses will come for the 12-weeks' course. These students who are for the most part in their second year of training, are assigned to the wards on their first day and also start instructional sessions of approximately two hours a day. These classes reflect the progress made in teaching procedures within recent years. The emphasis is on informal teaching. Gone is the classroom atmosphere with students straining to catch each word the instructor utters and taking copious notes. Mimeographed material is provided each student and the greater part of the period is spent in informal table discussion in which students are encouraged to raise questions and to express their own views. Visits are also arranged to other hospitals for the mentally ill in the city.

However, it is in the Allan itself that the students receive their special-

ized training. They assist in the Day Hospital, that part of the Institute to which patients come during daylight hours and where they receive all the treatments they would receive were they resident, with the exception of one or two of the more involved methods. The student nurses learn about the work being accomplished in the Alcohol Centre and they serve in the therapy unit where ambulant patients come two or three times a week, for treatments lasting perhaps an hour or two. They are also informed about the organization of the Institute's follow-up services: (1) for general patients with whom contact is maintained for as long as two years; (2) that offered in connection with the prevention of recurrent depressions; and (3) the monthly checking of patients in the special schizophrenia follow-up instituted within the past year.

It is interesting to note that the results obtained by these three services have been most encouraging and that a number of individuals who might otherwise have required further hospitalisation can now be maintained in sufficient good health to carry on normal lives.

When it is realized that psychological problems exist in from 40 to 60 per cent of all patients seeking medical care, the importance of the work being done at the Allan Memorial Institute becomes evident. While these figures do not mean that the patients all require treatment by a psychiatrist, they do indicate that medical and nursing personnel today must have an ever-increasing knowledge of personality problems and of the treatment of emotional disturbances in order to fulfill their responsibility of caring for the sick and of maintaining the well-being of the healthy.

In the Good Old Days

(*The Canadian Nurse* — NOVEMBER 1914)

"We are only gradually awakening to the fact that hospitals have very urgent duties to their nurses which, in the past have been sadly and shamefully neglected — in particular, their hours of duty shortened and better food served to them . . . The bill of fare for the nurses should receive as much attention as that of the private patients. Moreover, it is useless to purchase the best provisions the market affords, then spoil them in the cooking and serving."

* * *

"There are hospitals where a student nurse is kept on night duty for six months at a time. This is worse than wicked, it is stupid — a stupid lowering of the whole tone of the nurse which should be carefully conserved as the best asset of the hospital. Stupidity is the one sin that this age of efficiency cannot forgive in a superintendent."

"The first of a series of lectures on the work involved in Military Nursing was most interesting and well attended."

* * *

"A total of 105 nurses have left for overseas with the first contingent."

* * *

"Antityphoid inoculation remains, unfortunately, on a voluntary basis in our army, and it is only possible to secure the benefit of its protection to our troops by persuading the officers and men of the reality of the danger of typhoid fever and of the protective value of the vaccine.

"The ideal of universal protection is, I fear, too much to hope for. But, with the support of the profession, we may hope to save many valuable lives and to minimize one of the gravest causes of depletion of the fighting forces."

The hospitality of Manitobans is traditional. Certainly we found it so when we toured their province by car during September. Everywhere the warm hand of cordiality and friendliness was extended. Though personal letters of appreciation can be written to a few, we ask all the hundreds of nurses it was our privilege to meet to accept our grateful thanks. We look forward to receiving items for our News Notes columns from you all frequently. Good luck to you! You are grand people!

Establishing Good Lactation

M. Doris Anderson

Is the importance of the easy flow of breast milk, and its availability to the baby realized by most doctors and nurses who attend the mother and baby during that first postpartum week? Dr. Edith B. Jackson, director, Department of Pediatrics, Yale University School of Medicine, says, "In the process of lactation, milk is secreted until the alveolar backpressure reaches a certain level, at which point the secretion is inhibited."

As a rule, on or about the third day a mother's milk comes in with a rush. Combined with the resulting hardness of engorged breasts, flat or inverted nipples make it impossible for the baby to nurse. Since pediatricians do not always make daily visits, some mothers are left unrelieved if there has not been an order written to express, pump or to use a nipple shield. Even if these orders are given later to relieve the discomfort, the damage has often been done. In a day or two lactation ceases.

A situation like this should never occur. In hospitals where the baby is put to the breast every three or four hours from birth there is far less engorgement than in those where the baby only goes to its mother to nurse every eight hours during the first three days. Sometimes a little engorgement can be softened by sponging well with hot water. Surely it is not necessary to get a doctor's order for a mother to give herself a "good wash"!

Inverted nipples should be attended to during the prenatal period. Some nipples do not appear inverted. The way to test them is described by Dr. Harold Waller, pediatrician to the British Hospital for Mothers and Babies, Woolwich, England.

> The areola is pinched between the forefinger and thumb just behind the base of the nipple. The pinch should cause the nipple to project away from the breast. If it shrinks back when this test is applied there is sufficient deep attachment to render breast feeding difficult. (See illustration.)

Slightly inverted nipples can sometime be pulled out by finger and thumb, but often a mother forgets to do this regularly. The most effective treatment is to wear shields which either pull the nipples out by suction or push them out by constant pressure on the outside of the nipple. Personally I prefer the latter kind, designed by Dr. Waller, called "Woolwich shields." Dr. Waller refers to this congested condition as being the same as when "the fetus is stillborn. Unless it can be relieved the same cycle of events follows: production ceases, milk is absorbed and the engorgement subsides, but it does so because reversionary changes have begun."

The second important reason for prevention of engorgement is to avoid cracked nipples, mastitis and subsequent breast abscesses. When a baby nurses, his jaws should compress the milk sinuses which lie directly behind or at the edge of the areola. He then pulls the nipple back into his mouth so that it lies between the base of the tongue and soft palate. If the breast is hard, even if the nipple protrudes, the baby cannot get this "mouthful of breast," consequently he nibbles on the nipple in his effort to get the milk. In nine cases out of ten this will cause cracks and blisters. If, during this period, it is impossible to soften the breast the baby should temporarily be allowed to nurse through a nipple shield. By far the best type is the all-rubber one called "Natural Nursing Nipple Shield." The baby should be put to nurse without the shield at the first opportunity.

Milk comes in at different times with different mothers, so during the first three days the baby should nurse at intervals of three or four hours. This gets the nipple used to being sucked on; keeps the little ducts open;

Miss Anderson has been an obstetrical supervisor in several of the large hospitals in Canada.

Fig.1
Normal nipple

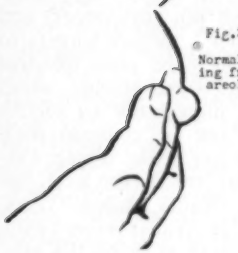


Fig.2
Normal nipple projecting from breast when areola is pinched.

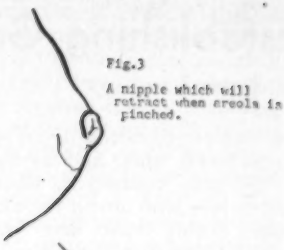


Fig.3
A nipple which will retract when areola is pinched.

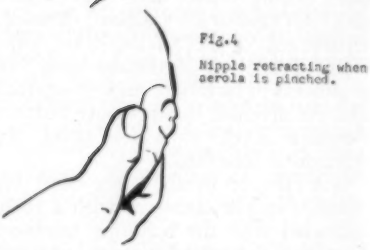


Fig.4
Nipple retracting when areola is pinched.

stimulates secretion and ensures the emptying of the breasts directly the milk comes in. In the process, the baby gets the colostrum.

Expressing a bead of colostrum once a day during the last two months prenatally has been found beneficial in keeping the lacteal ducts open. This prevents stagnation and thickening of the secretions in the ducts which may cause congestion by obstruction.

Is it kind to a mother to keep her and her newborn baby apart for eight hours at a time? I suppose this is meant to rest her — instead of that it worries her. She wonders why she does not see him. Is he all right? She hardly dares to ask. What about the "letting down" reflex? Ely and Peterson made a study on dairy cows and found that the posterior pituitary gland releases oxytocin. "This oxytocin reaches the breast by the blood stream, and then acts on the contractile cells surrounding the alveoli. From the alveoli the milk is forced into the larger ducts and becomes available to the baby." The pituitary gland is more likely to stimulate secretions when the mother is looking at her baby and loving him, than when she is lying alone in her room for half a day wondering if he is all right in the nursery.

Most obstetricians acknowledge the fact that the act of breast feeding by a newborn helps uterine contractions. Then, why is it that in so many hospitals the baby is not allowed to breast feed regularly from birth? Surely it would be better to put the baby to the breast directly it is born rather than to wait for twelve hours, as is often the case.

I have noticed that breast feeding is becoming the "fashion" with young mothers in Canada. I feel that it is a challenge to us to do every thing we can to help them succeed. Sir F. Truby King, who has done so much for mothers and babies has said:

> The first practical step towards ensuring normal motherhood is to bring back to women faith in themselves — which is another way of saying faith in the Almighty. Nothing militates more against easy, natural unassisted childbirth, and against the normal power to suckle offspring, than lack of self-confidence; and it is still worse for motherhood where the woman actually starts with the definite conviction that she is not going to succeed.

I feel this is all so true with Canadian mothers; they appear to have so little faith in themselves as good nursing mothers, so let us all do our best to help them.

If you have to keep reminding yourself of a thing, perhaps it isn't so. — MORLEY

Institutional Nursing

Visual Aids as Student Projects

Doris M. M. Springer

Many centuries ago, in their wisdom, the Chinese declared, "A picture is worth a thousand words." How sincerely all teachers agree with them! As medical knowledge increases, and we must crowd more and more facts into the nurses' curriculum, we have proved beyond doubt the value of "visual aids" in speeding up the learning process.

True, some excellent models and charts are on the market, but there are a number of instructors (myself included) who feel the need for learning aids other than those of the stereotyped pattern which many firms are still producing after 50 years and more. As none of these firms has taken advantage of the advice of those who use their products, we have had to resort to making our own.

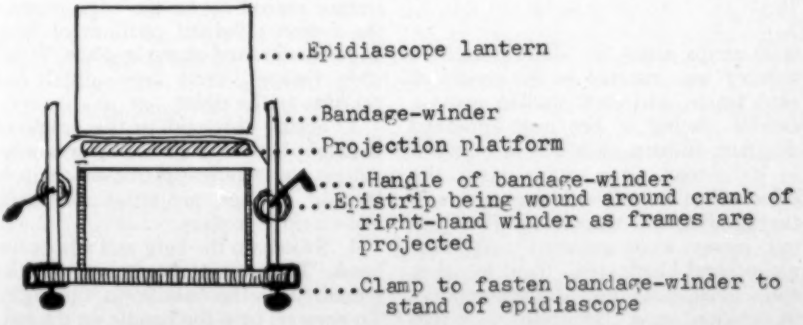
Possibly some of the "aids" which my students and I have evolved may be of interest to other instructors. Some months after the pre-clinical period, when we begin to consider medical and surgical nursing, comes the need to refresh fading memories of anatomy and physiology. It is for this purpose that I have found the *epistrip* very helpful.

The epistrip is designed for use with the epidiascope (bellopticon or opaque projector), and consists of a series of illustrations of uniform size, arranged on a strip of paper in the order in which they are to be projected. The strip is rolled (rather like a film strip) and fixed on the crank of a bandage-winder clamped to the left of the epidiascope. A blank initial end, about two feet in length, is passed across the projection platform and fastened to the crank of another winder on the right, the two winders being adjusted so that the pictures are projected squarely on the screen. By turning the handle on the right, it is then possible to show the "frames" one by one, as with a film strip.

The epistrip, however, has several advantages over the film strip:

1. After projection, it can be fixed to the wall, and referred to again by the students. Indeed, it can be used very effectively in this way, even if there is no epidiascope.
2. Being "home-made," it is cheaply produced, and it can also be adapted exactly to the requirements of the class for which it is intended.
3. Additions and subtractions are easi-

Miss Springer instructs student nurses at the Hammersmith Hospital, London, England.


....Epidiascope lantern
...Bandage-winder
...Projection platform
....Handle of bandage-winder
...Epistrip being wound around crank of right-hand winder as frames are projected
.....Clamp to fasten bandage-winder to stand of epidiascope

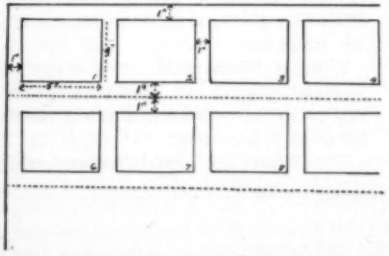
ly made — with a pair of scissors and a paste brush.

4. It can be folded, book-wise, and used as a reference book by students.

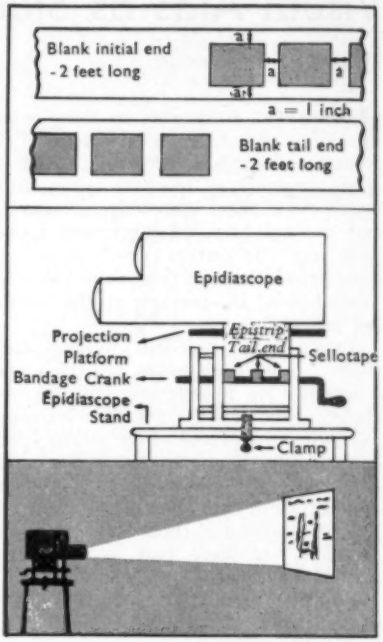
5. It can be made as a class project, as a form of review.

From our first epistrip, since we were experimenting with a new technique, we decided to adapt most of our illustrations from a well-known textbook on anatomy, and wrote to the publishers for permission to do so. We made a selection which we felt would illustrate the principles we wished to memorize, and decided on the order and size of the frames (4″ x 5″). Students were then allocated one illustration each, and we discussed what adaptations we should make. Each student copied the illustration as specified, producing a simplified version to satisfy our requirements. We then worked out the color scheme by which we intended to differentiate between the various structures. Labelling was written in with the aid of lettering stencils, and when the frames were complete, we laid them out in order and surveyed them critically. Taking account of suggested alterations, we passed on to the final stages of production.

We chose a paper with a smooth surface, ruled it as shown, and cut



it in strips along the dotted lines. A number was inserted in the corner of each frame, and each student made a careful tracing of her now approved diagram. In turn, each was then traced in its correct place on the strip, the colors filled in with drawing inks, and the labelling was completed. The various pieces were gummed firmly together, and blank strips fixed to either end. Then, with the bandage-winders in position, some "sellotape" to fasten the initial end, our epidiascope lenses and mirrors well polished, and the room darkened, we were ready for our first show.



HOW TO USE THE EPISTRIP

1. Starting from the blank two feet at the initial end, roll the strip, frames outward, until the tail end is reached.

2. Place a bandage-winder on either side of the epidiascope stand, just below the projection platform. Pass the "tail" end of the epistrip across the platform from right to left, and secure it to the crank of the left-hand winder with sellotape. (Numbers on frames should be on the edge nearest the screen.) Adjust position of bandage-winder, and clamp in place. Wind strip through until only initial end remains on the right.

3. Secure this end to the crank of the right-hand winder in the same way. Adjust this winder so that the strip is straight on the projection platform, and clamp it in place.

4. Switch on the light and adjust the focus. To project the frames on the screen, turn the handle on the right. To reverse, turn the handle on the left.

Industrial Nursing

Little Things Mean a Lot

THERESA GREVILLE

WHEN AN EMPLOYEE walks into your health centre, medical department, nurse's office or whatever you call your particular set-up, as a trained observer what thoughts come to your mind? If you are an oldtimer in the industrial health field, knowledge plus experience (which is the much vaunted woman's intuition) will tell you many things almost as soon as the door opens. It may be a fellow employee on routine duty to check on the maintenance, house-keeping, safety program, personnel work, possible length of time some key person may be away from work or numerous other reasons. It is always wise to be observant of these more or less regular visitors. Many people may drop in to have a few moments' change of scene from their own tense situation. A friendly atmosphere and an understanding may be all the treatment necessary. You must try to understand and accept the motivation or "angle" behind many visits; as those who have done counselling or listening know, it is only after the weather, furnace, golf game or garden have been discussed that the real problem or worry will be brought to light. While talking about trivial things your attitude is assessed: if favorable, you may have given help by allowing that patient with a troubled mind to verbalize his worry. He usually makes his own decision regarding the solution. You haven't had to do a thing but listen and you can more than likely forget about the whole thing. Unfortunately, we do not always have time for patient listening but a keen observer will nine times out of ten realize when the undivided attention of the nurse is needed.

Miss Greville is senior nurse with Canada Packers Limited, St. Boniface, Man.

Are we careful and objective in obtaining a concise history while observing the patient? Incorrect information by the patient is not always a lie or deliberate malingering, it may be the way the employee sees the story and the way he feels about this situation. For instance, the patient with an inflamed throat and general malaise, complaining about a dull backache, may be sure that it is because he lifted that box. A temperature check and a look at his throat may reveal the cause of the backache. He is treated for his throat and — presto — his back recovers! With girls who have neurotic types of headache, sore ears, torticollis — if you observe the fact that they are in the habit of having their hair pinned up in tight pin curls, and no doubt go to bed with wet hair nightly . . . it takes the diplomacy of a foreign minister to change this habit but if it can be done the symptoms very often subside.

Do we check for infected toenails when a patient complains of soreness in the groin? Compare limbs for difference in size when a sprain or strain is reported? Do we note the difference in the appeance of a new wound and one which has been neglected and reported days after it happened? Do we check temperatures thoroughly enough? It is amazing what you find! At our plant we invariably shake down the thermometer and check a second time if the temperature is up. Do we see that a person with recurring boils has a urinalysis?

What about the employee who walks in and says, "give me an aspirin." You may be trying to determine how to obtain the best treatment for your patient who has just reported shortness of breath and nausea; you must train the "give me an aspirin" boys to state their symptoms and once again you will

be surprised at the things you find. I usually explain either that we are not drug store clerks or that we give Lydia Pinkhams to the "give me an aspirin" boys. On the other side, I here and now want to say I have great respect for one aspirin every 4 hours; it comforts many conditions while Mother Nature, rest and good food heal the lesion caused by illness or accident.

How many times have you had people almost break down while telling you they are passing blood in their stool? When you really go into the history, they had beets for dinner the evening before. Strong odor to urine causing consternation may only be asparagus on the menu of the last meal . . . or the heavy smoker whose habit of cigarette smoking is so strong that he awakens during the night. He has his cigarette, also goes to the bathroom. This is the real story behind the night frequency and the negative cystoscopy with its chain of doctor and hospital bills. You may say this is too serious a symptom to neglect and you are quite right — but nurses and doctors should probably observe and talk more about their observations and negative findings.

You all know of simple cases of intestinal disturbance, vomiting and diarrhea. It burns itself out in 6 to 24 hours, then when the appetite returns a simple meal of tea and toast should be recommended. The patient should be told he may appear constipated for a time because his 30 feet of bowel has been emptied. When the well-meaning mother or wife, advised by the neighbor, takes over, how often have we had people ill for as long as eight days because a laxative is given to the inflamed empty bowel and a vicious circle is started?

How about the case of eczema or dermatitis who takes a daily laxative while on expensive and palliative treatment or all the best that medical science can offer?

How about the backache that is really some pelvic disorder or hernia?

How about the chlorine in the water of swimming pools causing eye irritation?

What about the rashes caused by the use of too much bleach in the wash water? Or the corns caused by socks too short or shrunken by washing?

How many times do we have a request for thyroid or pills to take off weight? Are we ready with the proper answer for the weight control program? Do we remember that many people may be mixing your department's medication with his own doctor's prescription — given to his wife last year, no doubt!

We need to be familiar with the numerous medical care, sickness and accident policies that our fellow-employees are involved with. Many of these plans give only part coverage and the nurse, in the interest of her own mental hygiene, should try to remain calm when the employee explodes about the "small print clauses." The nurse may be very busy when the irate person arrives, all ready to board his bus for home. Then she should put first things first and ask him to come back. It would be well to remember that a great number of Europeans, those from the British Isles included, have been accustomed to some form of state medicine and are not quite familiar with our system of personal responsibility or "pay as you go" for services rendered.

The Lord said to His disciples in the garden "Watch and Pray." We have to do that and, in addition, have enough accurate information on health and its preservation to keep up with the sure cures written up in popular magazines by cleverly trained writers.

Industrial or occupational nurses are in the front line and usually route the patient to doctor, hospital, or way to health with as little mental trauma as possible. It is apparent then that hospitals, universities and provincial and federal departments of health should continue to work out educational programs to further the professional and cultural education of the nurse.

It is easy — terribly easy — to shake a man's faith in himself. To take advantage of that to break a man's spirit is devil's work. — G. B. SHAW

Public Health Nursing

Safeguarding Health in Ontario's Vast Northland

HEALTH inspection services in the province of Ontario fall into two distinct categories. The inspection facilities in the more populated areas of the province are usually vested in the municipal health departments. In the vast unorganized areas of the province the job is assigned to roving inspectors of the Ontario Department of Health's Division of Industrial Hygiene. These inspectors, 10 in number, are stationed at various locations throughout the northland and are responsible for the sanitary conditions of lumber camps, mines and habitations serving the public in remote areas. In summer and winter, through heavy snow or a green landscape populated with thousands of blackflies, these inspectors keep a constant check on conditions that could lead to the spread or fostering of disease.

Ken Adams, an ex-RCAF flier is typical of these men. One of his newest problems is the building activity now underway at Lake Manitouwadge, site of the sensational new base metals strike that has rekindled the "strike it rich" fever among prospectors all over Canada. The lake, only a year ago a small blue dot in the green, forested wilderness north of Lake Superior, is now a scene of intense activity as planes and helicopters pour in men and materials to the area that will one day be as large as some of the famous mining centres of the north.

Using the northwestern Ontario centre of Geraldton as headquarters, Adams must make certain that the water supplies of this camp are kept pure to prevent the possible spread of infectious disease. He takes frequent water samples and has them tested at the nearest public health laboratory which, in this case, is at the Lakehead.

A constant check on the camp water supply is required.

Housing for the workers must come up to standards rigidly set by the Department of Health. To get to and from the mine location, Adams relies on a friendly helping hand from the Department of Lands and Forests as he "hitches" a ride on one of their regularly scheduled bush flights. Mining companies are unanimous in their praise of these health inspectors and are only too glad to offer their utmost cooperation.

Let's switch the scene now to winter. Four feet of snow lies heavily in the bush. The temperature is low. The forest resounds to the high pitched whine of the power chain saw and the

Health inspectors travel by every available means.

This article was prepared by the Public Relations Division, Ontario Department of Health.

sharp snick of the axe. Hundreds of lumber camps are engaged in the annual winter "cut." The sanitary facilities of these camps come under the constant scrutiny of the inspectors. Water supplies are kept under surveillance; the living quarters are inspected to make sure they are airy, well-heated, clean and comfortable. The lumber companies are just as concerned with these factors as are the health inspectors, for a happy lumberman means a good worker.

Summertime brings an entirely new problem into focus. The warm weather brings thousands of holiday seekers by rail, air and car, bent on seeing the great Ontario northland they've heard so much about. To cater to these visitors, private business men have erected hundreds of small tourist camps. Some of these establishments are on well-paved highways, some on bumpy logging trails and some are inaccessible except by air or canoe. No matter where the locations, they are inspected to ensure proper health standards. This visit by the inspector serves the twofold purpose of keeping health standards high and leaving a good impression with the visiting vacationers, who in turn will probably return to Ontario to spend more dollars next year.

As the heat of summer is gradually replaced by the chill of early autumn and the skies are filled with long, scraggly, V-shaped formations of geese on their way southward, a new problem arises for our inspectors. Pouring into the north from the United States and the larger centres in Canada come hundreds of men with glints in their eyes and guns in their cars. It's hunting time again. Many of the northern tourist locations immediately transform themselves into hunting camps though some are built exclusively for the short season. Again, the roving inspector pays his regular call to make certain health standards are high.

Inspecting the kitchen facilities of a lumber camp near Longlac.

Actually, the inspector in the unorganized areas of Ontario has more power than is given the inspector in the urban organized centre. He has the same power as is vested in the medical officer of health or board of health in the urban or rural organized area such as:

The northland health inspector is responsible for sampling all water and milk supplies. As mentioned earlier, these are analyzed at the nearest regional laboratory of the Ontario Department of Health.

Buildings must be examined to make certain that they are properly constructed and fit for human habitation.

Inspection of food processing plants is one of the most important duties. Slaughter-houses, bakeries, etc., are all inspected.

Restaurants are inspected quite frequently because of the short time it takes for trouble to develop in a food-serving establishment that does not take the most complete sanitary precautions.

Communicable disease is another concern of the inspectors. They must keep an alert eye and ear for any disease outbreak. Upon locating any trouble, they immediately inform officials at the Parliament Buildings in Toronto and the Department of Health makes certain that all proper precautions have been taken to prevent any serious spread of the disease.

Administration of the inspectors is in the hands of the Ontario Department of Health's Division of Industrial Hygiene. Through Chief Inspector Dave McKee, men in the field are kept up-to-date on the latest legislation they will be asked to enforce.

Many and unique are the problems encountered by the inspectors. Returning late one night by boat on Lake Temagami, one inspector and the crew found their craft sinking under them. Heading toward shore, the boat sank completely about 500 feet away. The inspector and the crew swam to shore.

Reports, testing equipment, kit and everything else aboard "went down with the ship." Around midnight, when the party was overdue, a search party was formed at the nearest settlement. Without any dry matches the group was unable to build a signal fire. It was three or four in the morning before they were finally located.

Chief Inspector McKee recalls an incident that occurred on a lumber camp inspection trip. He was travelling across a frozen lake with a team of horses and a "jumper" when the ice collapsed. The horses were able to scramble through the break to firmer ice. McKee and the driver were dragged through the frigid water by holding tightly to the reins. Another 10 miles in the below zero weather, they arrived at the camp sheathed in ice, and "rather chilly" to say the least.

"Over 300,000 square miles of unorganized territory in Ontario is checked by our inspectors," says Health Minister Mackinnon Phillips, "This is over three-quarters of the total area of the province. Their part in the overall health picture is extremely important. Ontario's high health standards provide proof of the unmistakable value of these men."

In Memoriam

Ada (Northrup) Bauer died at her home in Newcastle Bridge, N.B., on July 26, 1954. She had been in failing health for the past year.

* * *

Mary Beauvais, who graduated from St. Mary's Hospital, Montreal, in 1953, was killed in an airplane crash near Cap de la Madeleine, Que., on September 6, 1954, at the age of 24. Since graduation Miss Beauvais had been on the staff at St. Mary's.

* * *

Ann Bell, who graduated from the Royal Victoria Hospital, Montreal, in 1919, died at Tavistock, Ont., on May 3, 1954.

* * *

Violet Vera (Gardiner) Brandiff, who graduated from the Royal Alexandra Hospital, Edmonton, Alta., in 1922, died suddenly in July, 1954. Except for a period of 10 years during which she worked in Hawaii all of Mrs. Brandiff's professional activities had been in Edmonton. For the past 10 years she was employed at the Baker Clinic.

* * *

Diane Bray, a student nurse at the Vancouver General Hospital, died suddenly in June, 1954.

* * *

Rotha Madge Irene Carpenter, a native of Cornwall, Ont., died on August 13, 1954, at Fort Erie, Ont., following a brief illness.

* * *

Mary Langford, who graduated from the Royal Victoria Hospital, Montreal, in 1906, died at the Verdun Protestant Hospital in September, 1954, after a prolonged illness.

* * *

Katherine MacLean, who graduated from the Saskatoon City Hospital in 1922, died at Saskatoon on August 27, 1954, at the age of 68. From 1929 until her retirement in 1948 Miss MacLean worked on the staff of the Saskatoon Sanatorium.

* * *

Mary Louise McLeod, who graduated from St. Paul's Hospital, Vancouver, in 1945 died on July 9, 1954, at the age of 32. Miss McLeod had worked in several centres in Western Canada. For the past year she had engaged in private nursing.

* * *

Priscilla Smith, who graduated from the Toronto General Hospital in 1905, died from injuries received when she was struck by a motor vehicle in July, 1954. Miss Smith had worked in Winnipeg, Vancouver and Australia.

* * *

Laura Webb, who served with the Victorian Order of Nurses for many years, died in Toronto on July 20, 1954.

It is impossible to enjoy idling thoroughly unless one has plenty of work to do.

— JEROME K. JEROME

Aux Infirmières Canadiennes-Françaises

Le Service Médico-Social

JACQUELINE GAGNON, B.Sc.H., M.S.S.

INTRODUCTION

NOS TEMPS MODERNES ont vu naître, à côté des professions médicales et para-médicales, une nouvelle profession: celle du Service Social. Son champ d'action est infini puisqu'il touche à l'humain dans toutes ses sphères et qu'il permet à celles qui s'y donnent de répondre au besoin instinctif de dévouement qui caractérise particulièrement l'âme féminine.

Certes, l'appel de toutes les souffrances et de toutes les misères humaines avait depuis toujours trouvé une réponse dans des coeurs charitables, et les infirmières ont à leur crédit ce rôle plein de bonté, de générosité, de charité. Mais il semble bien que les exigences actuelles, que cette tournure sociale des esprits aient voulu une réponse plus spécialisée aux besoins sociaux.

En contact perpétuel avec les misères physiques, en contact fréquent avec les misères morales, l'infirmière est déjà préparée pour le rôle d'assistante sociale. Et si excellente que soit la profession d'infirmière, il est incontestable que les progrès modernes et les obligations de la vie actuelle nécessitent une compétence sans cesse accrue de la part de celles qui veulent suivre véritablement le rythme des transformations qui bouleversent tous les milieux. C'est pourquoi, sur le plan humain, les études en Service Social répondent à cet idéal: elles cherchent à découvrir toutes les causes des maux sociaux, à résoudre les difficultés matérielles et morales, à rendre l'homme, quel qu'il soit, conscient de ses responsabilités et de sa valeur d'homme.

La maladie fut une des premières à susciter la création des services sociaux, car elle est vite source de désorganisation pour l'homme et son foyer. La maladie, en s'installant au foyer, crée souvent des problèmes très sérieux: séparation temporaire parfois prolongée, misère physique, incompréhension, intolérance, fatigue que cause la présence d'un grand malade. Que dire des problèmes dont elle est la cause, qu'ils soient d'ordre physique, psychologique ou moral. Or pour sauvegarder l'équilibre de l'individu, pour sauvegarder l'unité familiale cela nécessite dans certains cas des relations toutes de compréhension et de bonté, enfin toute une éducation auprès du malade et de son milieu.

Afin de mieux illustrer notre pensée, nous nous permettons de vous apporter ici, deux cas typiques de cancéreux présentement sous traitement. Ces exemples seront fort utiles pour l'exposé qui va suivre et nous avons préféré les placer ici; même si l'ordre logique exigerait leur renvoi à la fin de ce travail.

Madame Desforges a présentement 44 ans. Elle a connu une jeunesse assez orageuse puisqu'elle a été fille-mère à deux reprises. Son deuxième enfant est décédé en bas âge. Le premier, une fille, a été placé dans une institution de charité, la mère défrayant le coût de la pension jusqu'au jour où elle décida de se marier normalement. Au bout de quelques années, elle perdit son mari et replaça alors sa fille dans un orphelinat. Aujourd'hui, cette enfant ayant 18 ans, est retournée à la maison pour y constater que sa mère vit en concubinage avec un chômeur de 30 ans. Pour subvenir aux besoins de l'existence, Madame Desforges fait du service à domicile. Depuis un an, Madame Desforges fait un cancer du col utérin. Cet état anormal entraîna des troubles psychiques qu'elle s'efforça de soigner en absorbant des doses régulières de narcotique. C'est à ce moment là que le cas nous fut signalé. Nous y avons constaté que la misère physique s'y compliquait de troubles familiaux, la jeune fille n'acceptant pas la présence du beau sire. L'hospitalisation acceptée sans trop

de difficulté a permis tout d'abord d'éliminer les narcotiques dans une certaine mesure et facilitera, nous l'espérons, la solution du grave problème moral.

La pauvre Marie-Louise a 72 ans et depuis 37 ans, travaille péniblement comme aide-ménagère alors qu'elle a quitté sa famille domiciliée à la campagne. Elle est venue en ville où elle a rencontré de méchants loups. Depuis 7 ans, elle fait un cancer des deux seins, plaie nécrosée horrible à voir et à soigner. Lorsque son cas nous fut signalé, elle vivait depuis 17 ans, avec un monsieur qui a présentement l'âge respectable de 76 ans et qui touche la pension d'un vieillard. Ensemble ils font bon ménage. Toute l'éloquence et la conviction de l'assistante sociale médicale n'ont pas réussi à la convaincre d'accepter l'hospitalisation. A peine fut-il possible de la faire consentir à venir régulièrement à la clinique externe. Mais il y a une Providence pour les malheureux : les circonstances ont voulu récemment qu'elle se fracture un bras. Après avoir enduré son mal durant une semaine et consulté des charlatans, elle se décida enfin à l'hospitalisation. Elle n'y fut que trois jours. Espérons que cette pauvre Marie-Louise finira par comprendre que sa place normale, pour la santé de son corps et de son âme, c'est l'hôpital.

Ces cas, nous l'espérons, démontrent que la maladie appelle toute une action médicale, sociale et morale dans le milieu qu'elle atteint. Afin de bien situer le travail que nous présentons, définissons les termes, maintenant : *service social médical et clinique anticancéreuse.*

Le *service social médical* est un organisme destiné à aider le patient à résoudre les problèmes qui sont la conséquence immédiate de son état de malade, qu'il soit à domicile ou hospitalisé. Son objet porte sur la sauvegarde de la santé d'abord pour en venir à traiter les problèmes connexes. La maladie, en effet, crée un état pathologique qui empêche celui qui en est la victime de vaquer à ses occupations ordinaires, familiales ou sociales ou professionnelles. C'est donc le rôle du service social médical de fournir au malade les moyens, les conseils et l'assistance qui lui permettront de s'adapter à cet état passager, mais difficile et pénible. *L'amour du prochain constitue l'essence du service social* et combien cet amour doit être grand auprès du malade.

La *clinique anticancéreuse* est un service organisé de l'hôpital dont l'objet est le patient cancéreux. Son action porte : 1. Sur le dépistage, l'examen, l'hospitalisation et le traitement des cancéreux ; 2. Sur la surveillance prolongée des résultats thérapeutiques ; 3. La recherche sur l'étiologie, la prophylaxie et la thérapeutique du cancer.

La clinique anticancéreuse est un organisme vivant puisqu'elle nécessite l'effort soutenu d'un groupe de personnes qui conjuguent leurs connaissances, leur conscience professionnelle et leurs techniques pour la poursuite d'un but déterminé.

C'est alors que l'infirmière assistante sociale, d'abord par les connaissances médicales qu'elle a acquises, par son expérience au contact des malades, et puis, par sa formation technique en service social, peut jouer un rôle important, profondément humain à la clinique anticancéreuse.

Organisation Interne

La réhabilitation possible du cancéreux est une tâche des plus complexes : l'infirmière spécialisée en service social ne pourra, il va s'en dire, l'accomplir seule : son rôle, d'ailleurs, n'est-il pas de seconder dans toute la mesure du possible les médecins traitants ? D'autre part, sa mission est également de préparer le patient à accepter sa condition et les traitements destinés à l'améliorer. Cette mission, on le comprendra, ne peut être mené à bien que si toutes personnes du service acceptent de mettre en commun leur science et leur dévouement dans une unité d'action pour le plus grand bien du malade. Il faut nécessairement le travail, la compréhension de tout le personnel de l'hôpital, car la clinique anticancéreuse doit être reconnue comme une partie intégrante de l'organisation interne de l'hôpital. Pour atteindre efficacement son but, il doit exister une direction permanente, composée des chefs des différents départements, de l'infirmière assistante sociale, d'un secrétaire.

Cette collaboration étroite des efforts

dirigera son action pour le soulagement si non pour la guérison du cancéreux. Chacun dans sa spécialité doit avoir le souci d'apporter au malade non seulement sa compétence professionnelle, son dévouement mais aussi des réalisations pratiques, c'est-à-dire, mettre à la disposition du malade toute la thérapeutique que nous pouvons attendre dans un hôpital bien organisé: des examens précis, des appareils selon les standards requis, des archives selon les normes des associations professionnelles.

Role de l'infirmiere assistante sociale

L'infirmière assistante sociale est constamment penchée sur la misère humaine: afin de la soulager, que peut-elle faire dans une clinique anticancéreuse? Souvent, hélas, elle ne peut donner qu'un bon mot, tenter de faire naître un sourire, porter une main secourable: mesdames, elle doit aimer ses malades, ses cancéreux.

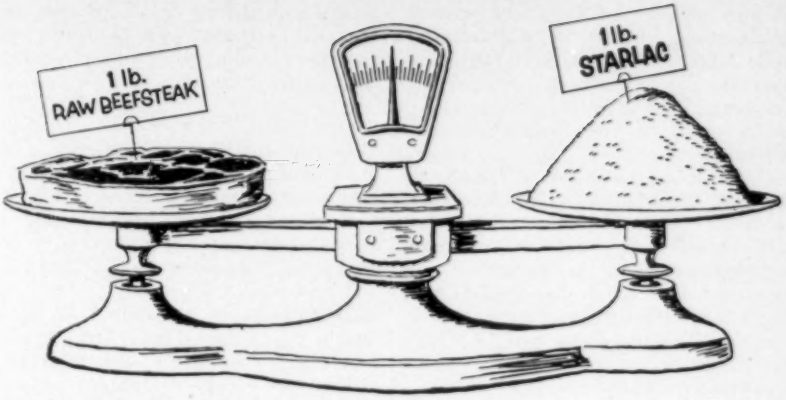
2. Son travail s'accomplit en deux étages: 1. le premier contact, 2. le travail médico-social proprement dit.

Premier contact: Dans une clinique anticancéreuse, l'infirmière assistante sociale doit servir d'intermédiaire entre le médecin traitant et le patient. Son action s'exerce de façon toute particulière au bénéfice du malade. Dès la première entrevue, elle devra s'enquérir de son histoire médicale. Elle s'intéresse ensuite à son histoire sociale, à ses problèmes familiaux, financiers, psychologiques, puisque l'ensemble de ses problèmes est inséparable de l'état pathologique. On a signalé, et avec raison, l'influence du moral sur le physique. On comprendra, dès lors, quels services inappréciables peut rendre une infirmière spécialisée en service social. Ses connaissances psychologiques et ses techniques de travail social lui permettront de mieux disposer le patient à accepter les services du médecin pour en tirer le maximum de profit.

L'histoire médicale et sociale du malade étant ainsi préparée, il appartient à l'infirmière d'en faire part au médecin qui le traite. Ces renseignements préliminaires permettront à celui-ci de se faire déjà une opinion précise sur le patient et sur l'attitude qu'il convient d'adopter à son égard. Le médecin fera alors son examen, il posera son diagnostic et recommandera le traitement le plus adéquat. Si l'hospitalisation est jugée nécessaire, l'infirmière doit appuyer cette décision, la faire accepter en démontrant au malade que le séjour à l'hôpital favorise des examens plus satisfaisants et des soins plus efficaces.

Dans une clinique anticancéreuse, la responsabilité du diagnostic et du traitement incombe à plusieurs personnes: médecin, chirurgien, radiologiste, anatomo-pathologiste, radiothérapeute auxquels seront adjoints des représentants des différents services. Lorsque le spécialiste a vu le patient, il est important qu'une conférence de cas les réunissent avec l'infirmière assistante sociale, afin d'aviser de la ligne de conduite qui doit être suivie pour le traitement. Cette mise en commun des constatations individuelles dans le domaine médical aussi bien que sur le plan social et psychologique, permet d'assurer l'unité d'action et une collaboration plus efficace pour le plus grand bien du malade. De plus cette étude globale des différents aspects d'un cas particulier permet à l'infirmière assistante sociale de mieux comprendre le rôle qu'elle doit jouer, auprès du malade et de seconder plus efficacement tous les spécialistes traitants.

Travail médico-social: Après le premier contact avec le personnel de la clinique anticancéreuse, le patient est fixé sur son cas, à savoir s'il doit être hospitalisé où s'il peut retourner dans sa famille. Grâce au travail préliminaire de l'infirmière, le patient accepte l'hospitalisation dans la plupart des cas: mais il y a lieu de distinguer entre le patient convenablement fortuné et celui qui n'a aucune ressource. Dans le premier cas, il semble que l'hospitalisation paraîtra moins pénible, en raison des services multiples que la fortune permet de se procurer. Dans le second cas, l'infirmière assistante sociale a parfois beaucoup à faire auprès de ces malades pauvres obligés d'accepter les services hospitaliers dans une salle commune. Le séjour à l'hôpital offre cependant aux uns et aux autres qui souffrent des



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Borden's

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mêmes misères physiques et souvent morales, les services de l'assistante sociale médicale, qui, de son côté, peut exercer à leur endroit un apostolat fructueux tant au point de vue social qu'au point de vue psychologique et religieux.

Lorsque le traitement a donné des résultats qui permettent le retour dans la famille, l'infirmière doit se préoccuper d'assurer au malade un minimum de bien-être et les médicaments indispensables à son état. Elle le disposera aussi à rester en contact avec la clinique, soit par les visites qu'elle pourra lui faire, soit par les examens périodiques, soit par la correspondance.

Dans une clinique anticancéreuse, il y a aussi le patient externe, c'est-à-dire, celui qui vient à l'hôpital pour des traitements définis. Nous pourrions également ranger dans cette catégorie, tous ces malades qui, après un séjour à l'hôpital ou une série de traitements, demeurent sous l'observation du médecin ou de l'infirmière assistante sociale.

Dans ce cas, le rôle de l'infirmière consiste à veiller à ce que le malade demeure en relation périodique avec la clinique anticancéreuse. Lorsqu'il s'agit de patient dont les ressources pécuniaires sont à peu près nulles, l'infirmière doit leur assurer tout ce que requiert leur état, tant au point de vue médical qu'au point de vue social et religieux.

Selon les problèmes du milieu, l'infirmière assistante sociale doit recommander le patient ou sa famille à d'autres services qui par leur nature, répondront plus adéquatement aux besoins. C'est alors qu'elle doit s'assurer la collaboration de tous les services sociaux de son milieu; service familial, service de placement, centre de réhabilitation, société de bienfaisance telle que la société canadienne du cancer, dans le cas, qui distribue aux patients à domicile, les pansements nécessaires à son état.

Conclusion

Ce bref aperçu illustrera, nous l'espérons, la nécessité du service social dans une clinique anticancéreuse et le véritable rôle qu'y joue l'infirmière spécialisée. Le développement de chacun des membres, l'acquisition des techniques médico-sociales, l'utilisation de tous les moyens pour la poursuite et la réalisation de la même fin. Pour sa part, l'infirmière assistante sociale adhère totalement à cette réalisation par son assistance au médecin, sa compréhension vis-à-vis du malade, l'interprétation de son cas, en un mot sa collaboration parce que là, justement, elle met en oeuvre les ressources dont l'institution ou la société disposent pour permettre au malade de traiter sa maladie convenablement.

L'infirmière assistante sociale pénètre dans tous les milieux par une action éducatrice et créatrice d'harmonie et de paix, pour qu'il y ait un peu moins de souffrance et un peu plus d'amour parmi les hommes. Elle est de par sa profession même, en contact avec tous les problèmes humains: elle exerce une action lente, continue et profonde sur le pauvre malade par sa qualité de technicienne qui attire pour chercher un appui, un conseil ou un soulagement. Son action est sans limite. Tâche immense et qui ne trouve sa source que dans cet amour du prochain qui porte à consoler ceux qui souffrent, à guider ceux qui tendent la main, à relever ceux qui trébuchent; tâche dont la fécondité est subordonnée à la morale qui l'inspire, la morale du christianisme.

Suburban Population Growth

Suburbs are the fastest growing areas in the country. During the 1940-1950 decade, the population in communities bordering our larger cities increased more than three times the rate of growth within these cities.

The growth of suburbs is not a new phenomenon; their development was already well under way at the turn of the century. Even in the early 1900's, when our cities were absorbing large numbers of migrants from farms and from foreign shores, the rate of growth was somewhat greater in the outlying areas than in their central cities.

—*M.L.I. Statistical Bulletin*

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Birch River Hospital Unit

MARY K. TENNIS

I WELCOME THE OPPORTUNITY of telling the readers of The Canadian Nurse something about Birch River Hospital Unit. This is a modern, ten-bed unit, with all the essential facilities for the care of patients, which was opened in 1949. It is located further north than municipalities have been made in what is known as "unorganized territory."

Government business is done from Winnipeg through the Department of Public Health and Welfare. The welfare service pays for many of the patients since this is a sort of pioneer area and is not very wealthy. Treaty Indians are paid for by the Federal government. Blue Cross has many subscribers. Actually we have few "white collar" patients.

Until last year, there was only one doctor for this area with the occasional assistance of the doctor from Swan River during surgery clinics which are held periodically. Last year another physician came from England. His wife, a nurse with much surgical experience in England, is an asset to him and the district. With her assistance, the new doctor handles some surgery here — usually emergencies.

This district boasts a lower infant mortality rate than any area in Manitoba. I believe this is due to the patience and capability of our doctor who has delivered over 1,000 babies in the past twenty years and has resorted to instruments only 8 times.

Four nurses are considered a full nursing staff, including one registered nurse who acts as matron. We count ourselves fortunate to have on staff two local registered nurses who are able to leave their family responsibilities long enough to take an 8-hour shift each. We have some very capable licensed practical nurses but, unfortunately, most of them stay here for only a few months at a time. We have also an untrained aid who works on the same shift as the matron.

I think, perhaps, the problem of securing staff nurses for this hospital is worse than many others because it is so far from the city and has poor transportation facilities. Matrons generally stay about one year. I served a year, then retired from the profession because of my age, family responsibilities and physical disability. I was called back to fill a temporary need, which proved to be not quite as temporary as I had hoped. Relief was indeed difficult to find. I stayed till I was no longer able to walk.

This hospital has a caretaker, a cook, and a laundress who also does the maid's work. For four years they had their own power plant, run by the caretaker, always on call. Their water and sewer system were also attended by the caretaker, and, as is usually the case, caused many headaches.

This is a suitable place for a nurse with good business ability, who can meet the public well and who does not care too much for social life. The matron is always on call. It is definitely a good place to save money. Younger nurses should go to hospitals like this to take the place of those who are ready to retire. Everywhere in nature the old are replaced by the young. Why shouldn't this happen on small hospital staffs?

Mrs. Tennis who was matron of the Birch River Hospital Unit now resides in Virden, Man.

The individual who is best prepared for any occupation is the one whose intelligence has been so well trained that he is able to adapt himself to any situation, and whose point of view has been so humanized by his education that he will be a good person in any job or calling. These qualities are the result only of a liberalizing education. — MORTIMER SMITH.

For control of diarrhea

In common diarrheas, KALPEC soothes the irritated bowel and leads to the production of well-formed stools. Kaolin has high adsorptive power, removes irritants from the bowel; pectin and alumina gel exert demulcent action. These features, useful in the common diarrheas, help in diarrhea associated with broad-spectrum antibiotics.

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Student Nurses

Thyroidectomy

NELLIE WHEELER

MRS. LEE was a thin woman, 70 years of age, who had been a widow for several years. She belonged to a well educated family, and was a prominent person in a wide range of community activities. Her family history revealed only pneumonia in 1950 which probably has no significance to her present symptoms. On her visit to the doctor, she apparently told him that she had had "thyroid trouble" ten years ago and was again suffering from distress in her throat, loss of appetite, loss of weight, extreme nervousness and exhaustion. With these symptoms, she was instructed to enter hospital where she was to have her metabolism measured in order to determine the activity of the thyroid gland, hyperthyroidism being suspected. Mrs. Lee was instructed to retire at 9:00 p.m. in her quiet room where she was to remain completely undisturbed until the technician came to take her test in the morning. The test read +12, normal being + or —10. This was not necessarily indicative of thyroid dysfunction. However, due to the distressing symptoms which she presented, she was advised to remain in hospital where her condition could be observed and tested. During this time she was given a full diet, bathroom privileges and so on.

Mrs. Lee's medical history presented the following information: Thyroid trouble ten years earlier for which she received Lugol's iodine. The iodine seemed to help her and she had remained fairly well until two months ago when she felt some distress in her throat and became very nervous. Since then she has been nervous and exhausted and has had no appetite. She gets easily out of breath and has an irritating hacking cough. Her voice has sounded peculiar. She has had no real pain in her throat, but sometimes has distress. She has lost 10-12 pounds in the past few months. Her chest x-ray revealed narrowing of the trachea above the level of the clavicle with displacement to the left but with no extension of tumor into the chest. The remainder of head, shoulders and the lung fields were normal. Examinations of chest, abdomen, reflexes and eyes found them normal. Her blood pressure was 110/70, pulse 105 per minute.

Thyroid gland: In the right lobe was found a hard, mobile, slightly irregular tumor the size of a hen's egg occupying the lower two-thirds of the gland and extending into the isthmus. In the left lobe there existed a hard smoother tumor the size of a pigeon's egg occupying the lower half of lobe.

There were no other palpable glands.

The laboratory findings were: Urine —few pus and epithelial cells; blood — hgb. 69%, red blood cell count 3,440,000, white blood cell count 11,600.

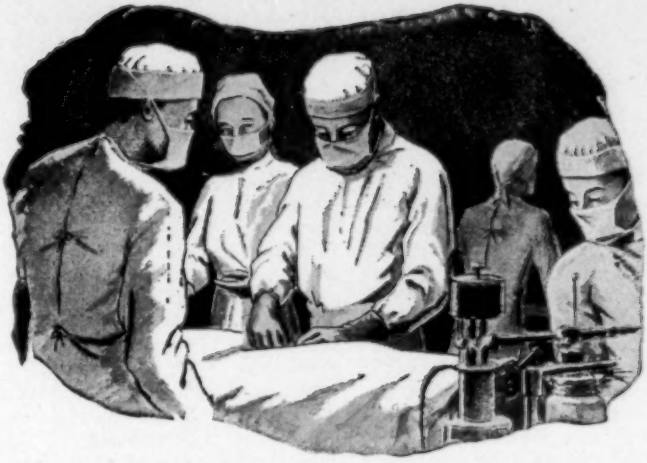
With the above findings, her condition was diagnosed as adenomatous goitre, probably malignant on account of its extreme hardness with mild thyrotoxicosis and thyrotoxic heart. A consultation was held and removal of the gland was considered essential. It was decided to operate immediately.

The reasons for removal of the gland were:

1. If left untreated, there would be increasing cardiac damage.
2. Difficulty in breathing and distress caused by the pressure of the tumor.
3. Probability of the gland being malignant.

Mrs. Lee was given 500 cc. human blood in preparation for operation. She was given the usual routine care by mouth after midnight, soap suds enema

Miss Wheeler wrote this study as a student nurse of the Carleton Memorial Hospital, Woodstock, N.B.



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and a barbiturate to insure a good night's rest.

The next morning Mrs. Lee was given Atropine gr. 1/150 one hour pre-operatively in order to lessen secretions. An hour later Avertin 4.5 cc., a basal anesthetic, was administered rectally. This basal anesthetic is given to patients who are to undergo thyroidectomy due to its power to diminish consciousness and apprehension, the long sleep it affords following operation, decreasing need for analgesic drugs and amnesia which extends from its administration to several hours post-operatively. Pre-operative care included also mental preparation of the patient by allaying her fears and kind, patient reassurance. At 8:15 a.m. Mrs. Lee was taken to surgery where she had a total thyroidectomy. The whole gland was dissected and removed with exposure and careful preservation of the recurrent laryngeal nerves. The gland was thought to be malignant at operation owing to its extreme hardness, the presence of many small hard lymph glands in the operative area and the fact that the gland was so firmly adherent to the trachea. Fortunately, however, the examination of the gland revealed Riedel's struma or chronic thyroiditis with no malignancy present.

Mrs. Lee returned from surgery at 11:00 o'clock. She was flushed, her breathing difficult, pulse 98, respirations 45. Since constant care and observation were essential, a student was instructed to remain at her side for several hours until relieved by special nurses. The dangers involved were:

Local hemorrhage from the incision.

Obstruction to the respiratory tract due to laryngeal inflammation.

Atelectasis or collapse of lung, the prevention of which requires the administration of cough suppressing sedatives.

Tetany caused by a reduction in the concentration of blood calcium which follows removal of the parathyroid tissues.

Injury to recurrent laryngeal nerves which may be suspected if the patient's voice is very hoarse and wheezy.

Also a close check must be kept on the patient's color and pulse.

Shortly after returning to her room, Mrs. Lee became cyanotic with difficulty in breathing and a rapid pulse. The doctor was notified and Mrs. Lee was given caramine and adrenalin, both heart stimulants, and was placed immediately in an oxygen tent. In half an hour her color was improved but her breathing became very difficult once again, her pulse slow. She became very cyanotic with mucus in her throat. This time the doctor was forced to perform a tracheotomy — a small incision is made into the trachea and a tube is inserted to facilitate the patient's breathing. The oxygen was then discontinued. In an hour, her pulse, color and respirations were improved again. Special care had to be given to the tracheotomy. Suctioning of the tube and wiping away of any oozing exudate is absolutely necessary every 10-15 minutes to remove mucus which inevitably collects and obstructs breathing or which may be aspirated, causing a lung condition.

Mrs. Lee was given sips of water and other cold fluids. She had some slight difficulty in swallowing and cold fluids were better tolerated. An intravenous infusion of 1000 cc. glucose and saline was given to prevent dehydration. Mrs. Lee was also troubled with post-operative retention of urine and had to be catheterized; then she was able to void naturally. Immediate post-operative orders were:

1. Demerol 100 mgm. when necessary for discomfort or pain.
2. Watch for tetany. An intravenous solution of calcium gluconate was always at hand for immediate use.
3. Keep in Fowler's position. This position facilitated breathing.
4. Penicillin to ward off any possible infection.

On the fifth day the tracheal tube was removed and nursing care became less specialized. Soon after this, Mrs. Lee complained of choking so was placed in an oxygen tent with filtered air to relieve her breathing difficulty. On the seventh day, she was given a soft diet. Clips were removed on the eighth day. The wound healed well and she was allowed out of bed on the ninth day for ten minutes. Following this, she felt fine except for very noisy and

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wheezy breathing. For this, steam inhalations were started. These were continued night and day when necessary with some improvement in her noisy breathing. Her appetite gradually improved and she was placed on a full diet as soon as it was well tolerated. The last week of her illness, Mrs. Lee was allowed out of bed fifteen to twenty minutes every day. Medications which she received during her convalescence were: (a) dried thyroid gr. 1 twice daily in tablet form; (b) Beminal fortis with vitamin C, one daily.

Day by day we could see that Mrs. Lee had greatly improved. Ten days from the time she was allowed out of bed, she was discharged from hospital, the prognosis being good. On discharge, her breathing was still very wheezy and partial laryngeal paralysis was evident. She was instructed to eat a nourishing diet, go to her doctor for a periodic check-up, and to avoid exertion. During her period of convalescence, Mrs. Lee was very apprehensive over the fact that perhaps the gland had been malignant and hadn't all been removed or that it would recur sometime. These fears were allayed by kind and sympathetic explanations.

Since discharge, Mrs. Lee's laryngeal paralysis has gradually recovered, until she now breathes quietly and without effort. It still recurs slightly with exertion. Her voice is stronger and clearer, she has gained some weight and has a good appetite. The only evidence of tetany she has had is numbness and tingling in her arms that has been controlled by calcium gluconate tablets by mouth.

Book Reviews

Heredity in Uterine Cancer, by Douglas P. Murphy, M.D. 128 pages. S. J. Reginald Saunders & Co. Ltd., 84 Wellington St. W., Toronto 1. 1952. Price $2.75.

Reviewed by Cleta Thompson, Instructor in Surgical Nursing, Royal Columbian Hospital, New Westminster, B.C.

An account of the research carried out by Dr. Murphy and his associates of the University of Pennsylvania is here presented in book form. Their study, undertaken to shed light on the question of the role of heredity in the etiology of human cancer, will doubtless prove of major significance in its contribution to medical science.

Data obtained as a result of this research relate to the incidence of cancer among relatives of 201 women suffering from diagnosed cancer of the cervix. Control observations on the families of non-cancer patients constituted the most original part of the work for Dr. Murphy's investigators. The evidence brought out is therefore more conclusive than that of other reported studies in which the validity of the control method had been open to considerable criticism.

The book is well set up, being divided into four sections and appendices. Each section is dealt with in detail and the terminology is clearly defined. The data of the research is presented in table form, followed by interpretative statements. Each section should prove of great value to those conducting research of this order.

The unbiased tone of this discussion is notable throughout. The language is that of the scientist, factual and emotionless, requiring careful sudy rather than casual reading.

Scientific workers in all the cancer fields, research or clinical, will doubtless evaluate the importance of this study by their own set of criteria. For the nurse, untrained in this type of research, the interest is solely academic.

Because of the limited field covered in this book it would seem inadvisable to recommend it for a text or reference book in a basic nursing course.

Les Relations Infirmière-Malade en Psychiatrie, par Helena Willis Render, R.N. 383 pages. (Traduction française par Pauline Lamy et Réginald Boisvert de "Nurse-Patient Relationships in Psychiatry," McGraw-Hill Book Co., Inc.) Publié par l'Association des Infirmières de la Province de Québec, 1538 ouest, rue Sherbrooke, Montréal 25. 1953. Prix $2.80.

Revu par E. V. LeBlond, Division de la Santé des Fonctionnaires Fédéraux du

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Après la lecture de "Les Relations Infirmière-Malade en Psychiatrie," on se rend facilement compte du rôle important de l'infirmière dans le nursing psychiatrique, car en plus d'en connaître les techniques dans toute leur complexité, la personnalité de l'infirmière et sa sympathie humaine se révèlent comme étant essentielles. C'est ainsi que l'auteur nous décrit chaque geste, chaque parole, chaque attitude — ferme et douce — de l'infirmière en psychiatrie, comme ayant une influence soit positive ou négative sur l'état immédiat du malade.

Plus que toute autre infirmière, l'infirmière en psychiatrie doit donc être maîtresse de ses propres émotions; elle doit être capable de supporter les injures et insultes, la colère et les désappointements puis, par son influence modifier les réactions négatives du malade, en tenant compte de la personnalité, de l'individualité et du rang social de son malade. L'infirmière en psychiatrie tâchera encore d'égayer l'atmosphère de ses salles. A ce propos, un des chapitres du livre comprend l'application des arts — littérature, musique, etc., comme thérapeutique; on y donne une foule de suggestions à ce sujet qui ne manqueront pas d'aider l'infirmière. Celle-ci devra également rassurer, donner confiance à son malade et atténuer cette peur navrante — lorsqu'elle existe — en ne perdant pas de vue le danger possible d'un suicide. Encore ici, l'auteur élabore longuement sur le traitement à suivre dans la prévention d'une issue aussi tragique que triste.

Pour aider l'infirmière dans ses dossiers, le livre renferme une liste complète d'expressions utiles dans la description adéquate de l'apparence générale et du tableau du comportement, lesquels, comme on le sait, prennent une signification particulière dans une salle psychiatrique.

De plus, à la fin de chacun des chapitres, on y trouve une longue liste de références, soit un véritable texte pouvant aider et l'institutrice et les élèves en psychiatrie. Bref, cet ouvrage nous donne une si vaste compréhension dans tout cet ensemble des problèmes et des relations entre l'infirmière en psychiatrie et le malade, qu'il devrait être porté à la connaissance de toutes nos infirmières et devenir un des recueils qu'elles voudront consulter.

Canadian Red Cross Society

The following are staff changes in the Ontario Division of the Canadian Red Cross Society:

Appointments — Haliburton: *Mary Bullis* (Kingston Gen. Hosp. and University of Toronto), as nurse-in-charge. Bancroft: *Kathleen Milne* (Toronto Western Hosp.). Beardmore: Carol Charters (T.W.H.). Burk's Falls: *Jane Norfolk* (Royal Hampshire County Hosp., England). Emo: *Gladys Wiles* (Victoria Hosp., London, Ont.). Englehart: *Edna Howell* (Royal Victoria Hosp., Montreal) and *Niina Teders* (German Hosp., Dalstone, Eng.). Hawk Junction: *Hilda Burch* (St. Michael's Hosp., Toronto). Hornepayne: *Dorothy (Cherry) Bauer* (Stratford Gen. Hosp.). Nipigon: *Anita Brennan* (St. Mary's Hosp., Timmins), *Lois Nicholson* (Strat. Gen. Hosp.), and *Anne Towsley* (McKellar Hosp., Fort William). Port Loring: *Irene King* (St. James Hosp., Batham, Eng.) Red Lake: *Jean Lowry* (Grace Hosp., Winnipeg). Thessalon: *Alberta DeKoning* (Wilhemina Gasthius, Amsterdam, Holland) and *Beverly Miller* (U. of T.).

Transfers — *Louise Bryant* from Thessalon to Whitney; *Esther Pedersen* from Hawk Junction to Beardmore, as nurses-in-charge. *Marjorie Eagles* from Emo to Rainy River. *Louise Grover* from Haliburton to Richard's Landing. *Elizabeth Hotson* from Rainy River to Burk's Falls. *Jessie Kirkland* from Port Loring to Callander. *Edna Millman* from Callander to Gore Bay. *Janet Proudlock* from Thessalon to Haliburton. *Nell (Bannister) Walker* from Nipigon to Beardmore. *Leita Williamson* from Englehart to Haliburton.

Leave of Absence — Hawk Junction: *Ruth (Weekes) Fahey.*

Resignation — Bancroft: *Bridget Hannan, Olive Thorogood.* Beardmore: *Bernice Kent.* Englehart: *Jessie Boyd, Jean Brown.* Haliburton: *Isabel Chester, Moira Austin.* Lion's Head: *Margaret Burt.* Nakina: *Olive Cruikshank.* Nipigon: *Evelyn Ashford.* Red Lake: *Jessie Cunningham, Margaret Dunlop.*

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The following are appointments and staff changes in the World Health Organization:

Appointments — Janet Cameron who was on the teaching staff of the Toronto General Hospital has been assigned to the nursing education project in Sandaken, North Borneo. She will be working with Evelyn Matheson. *Edith Green* of Victoria, formerly acting director, McGill School for Graduate Nurses, will proceed to Alexandria, Egypt, where she will be a member of the WHO staff assisting in the development of a Regional College of Nursing. Helena Reimer is the leader of the team. *Margaret Mackenzie* who was public health nurse on the staff of the Toronto Western Hospital has left for India. She will be a member of the team assisting in the All-India Institute of Hygiene in Calcutta. Her function will be to teach post-graduate public health nursing. *Gretta Pringle* who has been in Fort William, has left for Indonesia. She will be stationed in Bandung and will be helping in the development of a post-graduate course in public health nursing. *Marie Sauvé* who has been on the staff of the University of Toronto School of Nursing, has gone to Phnom-Penh, Cambodia. There, she will be a member of the team that is developing the first school of nursing in the country. *Roxie Wilson* arrived in Geneva from Viet Nam. She will be going to Teheran, Iran, to join the nursing team working in the Ashraf School of Nursing. She will be the pediatrics instructor. *Eva Williamson* from the Metropolitan Health Committee in Vancouver has gone to Colombo, Ceylon. She will be working in the school of nursing there helping to integrate public health nursing aspects into the basic curriculum.

Returned to Canada — *Muriel Graham* and *Ina Dickie*.

Other changes — *Queenie Donaldson* who first joined our staff and went to Addis Ababa, Ethiopia, on a V.D. Control project and was later transferred to a similar project in Karachi, Pakistan, has gone to Baghdad, Iraq, where she will be working in a T.B. Control program. *Mary Harling* was married and is now Mrs. Campbell. She is still on the staff in Penang, Malaya. *Marion Pennington* who has been in Turkey since 1952, is returning home. The project there has been completed.

Ontario

The following are staff changes in the Ontario Public Health Nursing Service:

Appointments — *Eola Scott* (Hamilton Gen. Hosp., University of Toronto general course and B.S., Columbia University, New York), *Jennette Gillespie*, B.N., formerly with Galt board of health, *Joyce Callahan* (St. Michael's Hosp., Toronto, and U. of T. gen. course), and *Bessie McKinlay*, B.A., (Collingwood Gen. and Marine Hosp. and U. of T. gen. course), as director, supervisor, and staff nurses respectively, to Simcoe County health unit; *Florence Tomlinson* (Kitchener-Waterloo Hosp. and U. of T. gen. and advanced courses), *Jean Kennedy* (Toronto East Gen. Hosp. and U. of T. gen. course), and *Jerrine Witzel* (Hosp. for Sick Children, Toronto, and University of Western Ontario certificate course), as senior nurse and staff nurses respectively, to Stormont, Dundas and Glengarry health unit; *Ella Beardmore* and *Doreen Murphy*, (both St. Michael's Hosp., Toronto, and U. of T. gen. and advanced courses), *Madeline Smillie* (U. of T. diploma and advanced courses), and *Dorothy (Somerville) Newhall* (University of Alberta Hosp. and B.Sc.N.), as supervisors and staff nurse respectively, with Toronto Dept. of Public Health; *Mary Vivian* (Kingston Gen. Hosp. and B.N.Sc., Queen's University) to Belleville Dept. of Health; *Ruth Snowden* (Brantford Gen. Hosp. and U. of T. gen. course) to Brant Co. health unit; *Alice Riddle* (B.G.H. and U.W.O. cert. course) to Chatham board of health; *Christena Miller* (Children's Hosp. of Michigan, Detroit, and U. of T. gen. course) to Cochrane board of health; *Agnes Clinton* (Women's College Hosp., Toronto, and U. of T. gen. course) and *Jean (Anderson) Williamson* (Toronto Gen. Hosp. and U. of T. gen. course), both

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(5) Box 292, North Bay, Ontario;
(6) 55 "B" St. Joseph Street, Quebec, P.Q.;
(7) Moose Factory Indian Hospital, Moosonee, Ontario.

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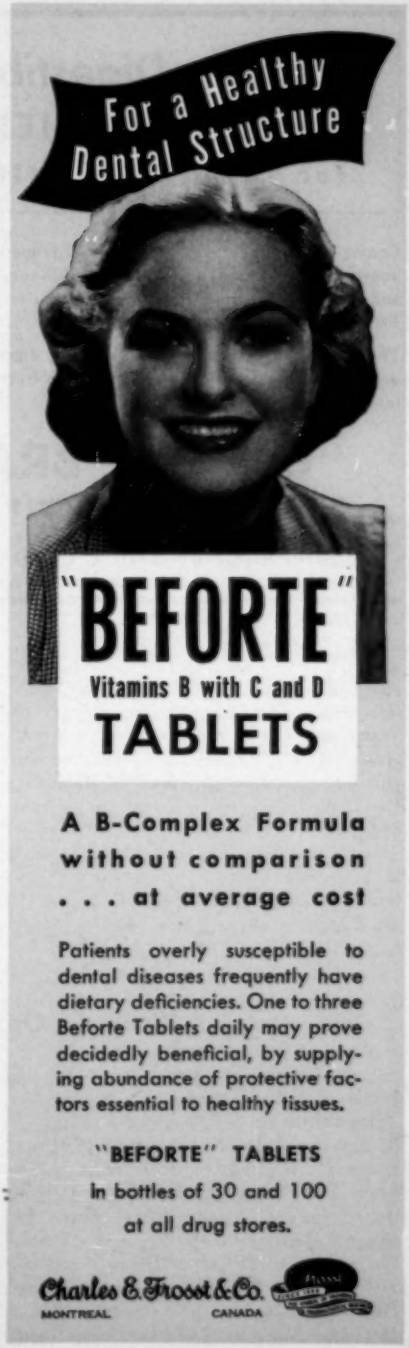
to East York-Leaside health unit; *Joan Cogdon,* B.A., (Metropolitan School of Nursing, Windsor, and B.Sc.N., U.W.O.) and *Eleanor (Smith) Graham* (Grace Hosp., Windsor, and U.W.O. cert. course), both to Elgin-St. Thomas health unit; *Ann Allen* (Wellesley Hosp., Toronto, and U. of T. gen. course), *Edith Holub* (Toronto Western Hosp. and U.W.O.), *Emily Imrie* (T.W.H. and U.W.O. cert. course), and *Jacqueline Martin* (T.W.H. and U. of T. gen. course), all to Fort William and district health unit; *Geraldine Graham* (St. Michael's Hosp., Toronto, and U. of T. gen. course) to Guelph board of health; *Audrey Gardner* (Toronto East Gen. Hosp. and U. of T. gen. course), *Julia (Dunn) Liphardt* (T.G.H. and U. of T. gen. course), and *Margaret Langtry,* formerly with Huron Co. health unit, all to Halton Co. health unit; *Patricia Campbell* (Chatham Public Gen. Hosp. and U.W.O. cert. course), *Angela Psutka* (St. Mary's Hosp. Kitchener, and U. of T. gen. course), *Barbara Sauer,* formerly with Kent Co. health unit, and *Janet Thomson* (Wellesley Hosp., Toronto, and U. of T. gen. course), all to Huron Co. health unit; *Helen Cruden* (T.E.G.H. and U. of T. gen. course) and *Lassy Malowany* (Winnipeg Gen. Hosp. and U. of T. gen. course) to Kenora-Keewatin-Dryden area health unit; *Joan McKenzie* (Saint John Gen. Hosp., N.B., and U. of T. gen. course) and *Ivy Michel* (O.C.H. and U.W.O. cert. course), both to Kent Co. health unit; *Virginia Hamilton* B.N.Sc., formerly with St. Catharines-Lincoln health unit and *Joy (Daniels) Waterhouse,* formerly with Oxford health unit, both to Kingston board of health.

Florence Kudoba (Stratford Gen. Hosp. and U. of T. gen. course) to Kitchener board of health; *Maryn (Hillis) Anderson* (B.Sc.N., U.W.O.) and *Jean Downer* (Demonstration School of Nursing, Windsor, and U. of T. gen. course), both to Lambton health unit; *Helen Colton* (Kingston Gen. Hosp. and U. of T. gen. course), *Jean (Lloyd) Lorimer* (K.G.H. and Queen's U.), *Ann McLaren* (Galt Gen. Hosp. and U. of T. gen. course) and *Evelyn Tindale* (H.G.H. and U.W.O. cert. course), all to Leeds and Grenville health unit; *Merilyn Dobbin* (Hosp. for Sick Children, Toronto, and U. of T. gen. course) and *Jessie Renton* (Stobhill Hosp., Glasgow, Scotland, and U.

of T. gen. course), both to Lennox and Addington health unit; *Olga Wallace* (H.G.H. and U.W.O. cert. course) to Michipicoten township board of health; *Lorna Wilson* (St. Michael's Hosp., Toronto, and U. of T. gen. course) to Muskoka district health unit; *Ruth Armstrong,* formerly with Muskoka district health unit, to North York township board of health; *Jean McGreer* (K.G.H. and U. of T. gen. course), *Jean Murray* (T.G.H. and U. of T. gen. course), *Doris (McAvoy) Stewart* (St. Mary's Hosp., Timmins, and U. of T. gen. course), and *Audrey Wale* (University of Ottawa School of Nursing and cert. course), all to Northumberland and Durham health unit; *Mary Carty* (St. Michael's Hosp., Toronto, and Queen's U.) and *Mary McCullough* (T.G.H. and U. of T. gen. course), both to Oshawa board of health; *Marilyn Bushnell* (Hosp. for Sick Children, Toronto, and B.N.Sc., Queen's U.), *Margaret O'Brien* (U. of O. School of Nursing and cert. course), and *Constance St. George* (St. Mary's Hosp., Montreal, and B.Sc.N., U. of O.) to Ottawa board of health; *Barbara Gallivan,* B.A., (St. Michael's Hosp., Toronto, and U. of T. gen. course) and *Elizabeth (Cooke) Hochner,* formerly with St. Catharines-Lincoln health unit, to Oxford health unit; *Mary Richard* (St. Joseph's Hosp., Victoria, B.C., and U. of O. cert. course) and *Isobel Tremblay* (St. Mary's Hosp., Montreal, and U. of O. cert. course) to Prescott and Russell health unit; *Dorothy (Sanderson) Stetler,* formerly with Michipicoten township board of health, to Peel Co. health unit; *Ann Cryan* (T.G.H. and U. of T. gen. course) to Prince Edward Co. health unit; *Helen Beavis* (Nicholls Hosp., now Peterborough Civic, and U. of T. gen. course), *Cora Lango* (Wellesley Hosp., Toronto, and U. of T. gen. course), *Eva (Secord) Metler* (H.G.H. and U. of T. gen. course), and *Sylvia Romanoff* (H.G.H. and U.W.O. cert. course), all to St. Catharines-Lincoln health unit; *Margaret Rattray* (St. Catharines Gen. Hosp. and U. of T. gen. and advanced courses) to Sault Ste. Marie board of health; *Aileen Burke* (St. Jos. H., Toronto, and U. of T. gen. course) to Scarborough township board of health; *Katherine Engler* (St. Jos. H., Hamilton, and U. of T. gen. course), *Ruth Maguire* (B.G.H. and U. of T. gen. course), and *Elizabeth Williams* (H.G.H. and U.W.O. cert. course), all to Timiskaming health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unit; *Alda Ruthven* (Guelph Gen. Hosp. and U. of T. gen. course) to Stratford board of health; *Hazel Thompson* (Guelph Gen. Hosp. and U. of T. gen. course) to Waterloo township board of health; *Grace Arnot* (T.E.G.H. and U. of T. gen. course) and *Jessie Graham* (St. Jos. H., Hamilton, and U.W.O. cert. course), both to Welland and district health unit; *Isabel Taylor* (Hosp. for Sick Children, Toronto, and U.W.O. cert. course) to Wellington Co. health unit; *Joan Milroy* (T.E.G.H. and U. of T. gen. course), *Laura (Miller) Shepherd* (Saskatoon City Hosp. and U. of T. gen. course) and *Dorothea Trann* (T.G.H. and U.W.O. cert. course), both to York Co. health unit.

Resignations — *Eleanor (Jamieson) Hurd*, B.Sc., M.P.H., and *Jewel Killorin*, as director and supervisor respectively, both from Simcoe Co. health unit; *Doris Dooley* from Cochrane board of health; *Ivy (Betts) Priest* from Niagara Falls board of health; *Dorothy Pickering* from Pr. Ed. Co. health unit; *Vida (Abbott) Johnston* from Waterloo township board of health.

Victorian Order of Nurses

The following are staff changes in the Victorian Order of Nurses for Canada:

Appointments — As nurse-in-charge — Brampton: *Ruth Ross* (Victoria Hosp., London); Liverpool, N.S.: *Maria Van Noort* (St. Antoniushove, Voorsburg, Holland); Port Colborne: *Mary Moss* (St. Joseph's Hosp., Hamilton); Waterloo: *Norma Flannigan* (Victoria Hosp., London). To staff — Brantford: *Mary Dowling* (Brantford Gen. Hosp.); Burnaby, B.C.: *Mrs. May Gillis* and *Dorothy Shields* (both Vancouver Gen. Hosp.); Corner Brook, Nfld.: *Evelyn Penney* (St. Joseph's Hosp., Glace Bay, N.S.); Hamilton: *Mrs. Shirley Foster* (Toronto Western Hosp.); Kitchener: *Stephanie Mason* (Metropolitan School of Nursing, Windsor); Saint John, N.B.: *Phyllis Miller* (Charlotte County Memorial Hosp., St. Stephen, N.B.); Sudbury: *Anne Dick* (Kitchener-Waterloo Hosp., Kitchener); Surrey, B.C.: *Mariann Barnes* (Edmonton Gen. Hosp.); Toronto: *Beverley Bell, Jeanne Leighton*, and *Carole*

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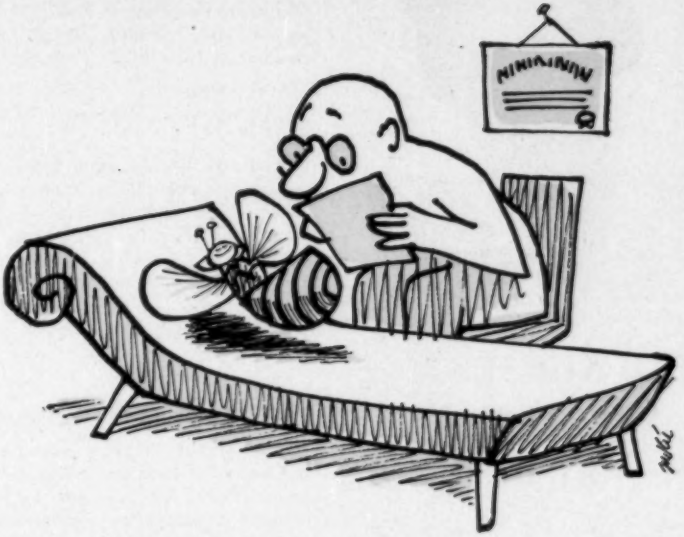

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Reappointments — Surrey, B.C.: *Thorun (Arngrimson) Urquhart;* Toronto: *Ada Scott.*

Transfers — As nurse-in-charge — *Norma O'Shea* from Cobalt, Ont., to Smiths Falls; *Helen Minaker* from Sudbury to North Bay; *Isobelle Sorley* from staff to N/C, Oshawa. To staff — *Marjorie Smith* from Whitby to Hamilton; *Norma Saimon* from Waterloo to Saint John, N.B.; *June (Fredin) Price* from Owen Sound to Hamilton.

Nursing Sisters' Association

Officers for the Toronto unit of the Nursing Sisters' Association of Canada for 1954 are as follows: Past president, D. Macham; president, F. Matthews; vice-presidents, B. Seeds, L. Fair; secretary, J. Deyell, Sunnybrook Hospital; treasurer, H. Rendell, 54c Maitland St.; and in other capacities, K. Braggs, K. Christie, M. Marshall, M. Porter, Mrs. A. L. Phelps.

Correction

Please note the correct price of the I.C.N. publication "An International List of Advanced Programmes in Nursing Education." On page 738 of our September issue it was given as 12 shillings. The actual price is 16 shillings — $2.00, in our currency. Write to the International Council of Nurses, 19 Queen's Gate, London, S.W. 7, for your copy.

Veuillez prendre avis que le prix de "An International List of Advanced Programmes on Nursing Education" est de 16 shillings ou $2.00 de notre monnaie et non 12 shillings tel qu'annoncé dans le numéro de septembre. Pour exemplaire, s'adresser au Conseil International des Infirmières, 19 Queen's Gate, London, S.W. 7.

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News Notes

ALBERTA

District 1

Peace River

In a summary of the activities of the chapter for the past year are the following: Nine regular meetings held with an average attendance of 12; visits of L. Kremer who spoke on Civil Defence and C. W. Perkins, then field representative for *The Canadian Nurse* on construction and publication of the magazine; immunizations with an average of 60 given each month at the Well Baby clinic; flowers sent to local student nurses when they received their caps; $25 given towards the purchase of a Chespirator for the hospital and funds increased by the sale of baby bracelets at the hospital and a bake sale; assistance by members in an immunization program for local school children. Officers were elected as follows: President, Mrs. H. Thompson; vice-president, Mrs. A. Bieraugel; secretary-treasurer, Mrs. B. McKenzie. Others serving are J. Wickett, Mmes K. Adams, D. Sproul, and G. Andrews.

District 3

Calgary

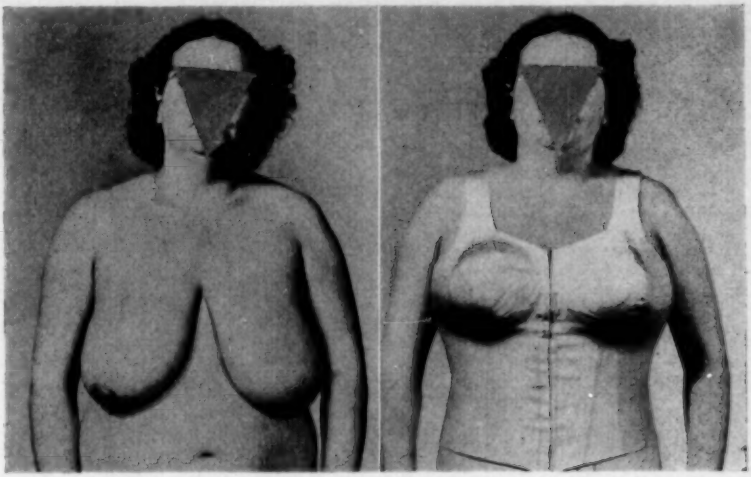
Holy Cross Hospital

A Get Acquainted tea with senior students as hostesses, a garden party by the sisters and faculty members and a dramatization of the first days of a "probie" were among the activities enthusiastically planned by the senior students to welcome the 52 preliminary student nurses during initiation week in September. Members of the faculty and student nurses regret that Sr. M. Trottier must resign as director of nurses due to illness and sincerely hope she may soon regain her health. The new director is Sr. C. Leclerc to whom a welcome is extended.

District 7

Jasper

The June meeting of the Edith Cavell Chapter was attended by 12 members. A



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proposed local T.B. clinic in the fall was discussed. Mrs. White, president, reported on her visit as delegate to the C.N.A. biennial convention in Banff.

Stony Plain

At the September meeting of the chapter it was noted that due to the loss of a member who moved away and the addition of a new one, the enrolment still totals 17. Mmes A. Willie and S. Mills volunteered to help M. Story with the twelve weekly classes in home nursing to be given locally. Discussion of programs for future meetings followed and Mrs. Willie gave an excellent report on high points of the C.N.A. biennial convention in Banff.

District 8

Macleod

Activities of Chinook Chapter for the past year include: Recommendations submitted to the Provincial Council for a definite minimum wage for nurses in Alberta, a dominion-wide registered nurses' examinations set by Canadians, a living-out allowance for married nurses, and a superannuation plan whereby nurses working to a pensionable age may receive a monthly benefit or lump sum while those retiring earlier may be refunded the sum they have paid in. $25 was donated to the Special Favors Committee for the C.N.A. biennial convention at Banff and over $60 realized from a pantry sale and cake raffle aided the funds used to send delegates, J. Jarman and M. Long, to the convention. They gave detailed reports of their trip at the meeting in June which took the form of a theatre party, followed by a Chinese supper at the home of the president, Mrs. P. Evans. L. Kremer outlined the progress of Civil Defence in Alberta at the March meeting and a food parcel was sent to Ada Sandell in Korea.

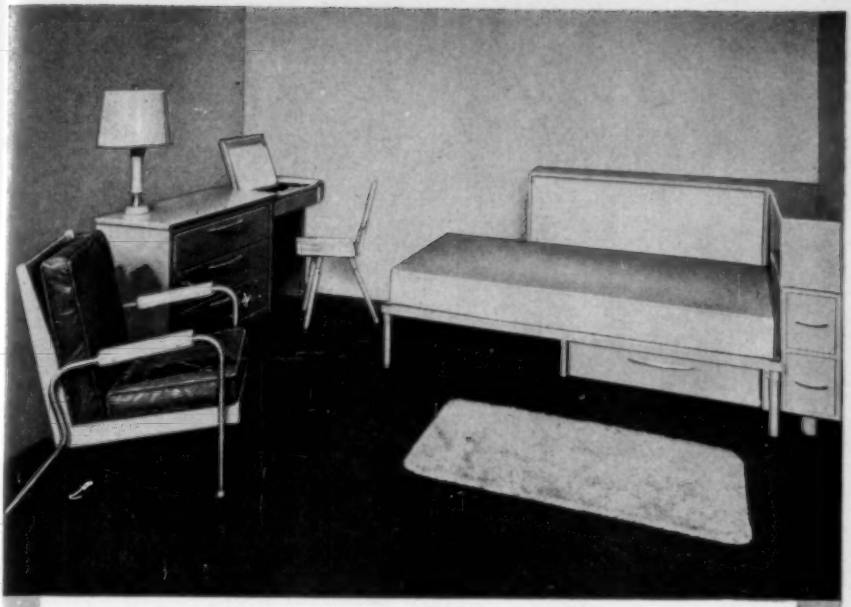
Pincher Creek

Among the projects sponsored by South West Chapter during the past year were: A bake sale to aid the Special Favors Committee for the C.N.A. biennial convention in Banff; a successful tea and raffle; films and interesting addresses that included a talk by Mr. Huckvale on the work of the Cancer Society, followed by the presentation by Mrs. N. Drope of the film, "What is Cancer?" A delegate attended the biennial convention and members assisted the blood donors' clinic and instructed the Girl Guild company in Junior first aid.

BRITISH COLUMBIA

Prince George

In the absence of the president, Mrs. S. Hill, Mrs. M. Maxwell presided at the September meeting of the chapter and E. Braund spoke on the highlights of the C.N.A. biennial convention in Banff. Dr. L. T.



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Maxwell, the guest speaker, gave a most informative paper on "The Medical Aspects of Alcoholism" and a lively group discussion followed.

TRAIL

At the September meeting of the chapter, the president, A. Baker, presided. It was decided to give $50 to assist P. Badgley, a student chosen by her high school, to enter nurses' training this year; a $150 loan from the Alice Chesser Memorial Fund was granted C. Beatty for the same purpose. Letters of thanks were read from: Mrs. E. (Keast) McDonald for the loan made to enable her to go in training; Mr. L. A. Read for the aid given in moving to the new hospital; and Dr. A. F. Balkany for the help of the nurses during the typhoid inoculation clinic.

Proceeds from the rummage sale amounted to $53.55 and a net profit of $53.30 resulted from the bake sale on opening day of the new hospital. Mrs. Belanger has replaced Mrs. Broman on the visiting committee and plans for lectures by Dr. A. F. Alvarez were discussed.

VANCOUVER

St. Paul's Hospital

Officers elected at the annual meeting of the alumnae association recently are: Honorary president, Sr. Superior; honorary vice-president, Sr. D. Marguerite; president, E. Black; vice-presidents, Mmes F. Gray, G. Collishaw; secretaries, Miss McAstocker, D. Corry; treasurer, S. Ingalls; assistant treasurer, G. Corcoran; committee conveners, R. Cunningham, B. Gilmour, H. Clegg, M. Freeze, Misses Unkevitch and Jefferson, Mmes M. Bell, B. Miller, A. Barnes. C. Connon is *The Canadian Nurse* representative.

MANITOBA

WINNIPEG

Children's Hospital

New officers for the alumnae association were elected recently as follows: President, Mrs. W. J. McCord; vice-president, D. Motrik; secretaries, P. Greenaway, M. Hall; and in other capacities, J. Boyd, S. O'Grady, S. Pitt, Mmes H. Davis, I. Moore, J. Brown, J. C. Kirby.

NEW BRUNSWICK

NEWCASTLE

The president, Sr. Skidd, presided at the September meeting of Miramichi chapter and Mrs. Paulson, acting as secretary in E. MacDonald's absence at Dalhousie University to take a course in nursing education, was appointed secretary. Discussion of matters to be presented at the annual meeting in Edmundston followed routine business and Mrs. Paulson read a report prepared by I. Loggie on her visit to the C.N.A. biennial convention in Banff.

ST. STEPHEN

M. McMullen was re-elected president for the third term at the annual meeting of the chapter recently. Other officers are: Vice-presidents, Mmes R. Higgins, M. Gibson; recording secretary, Mrs. B. Berry; corresponding secretary, Mrs. L. Carmichael; conveners of committees, C. Boyd, N. Spinney, A. Spinney, J. McCullough, D. Parsons, A. Mark, C. Dowling, Mmes R. Bartlett, H. Beek, H. Lawrence, W. Murdock, M. Gibson. Guest speakers during the year were: G. H. Mowat of St. Andrews who spoke on "Handicrafts"; L. Brownrigg on her trip to the Coronation and Mrs. M. Brockway on her visit to Hawaii. Members acted as

guides at the opening day of Charlotte County Hospital, on Hospital Day, during the visit of delegates from the Maritime Hospital Association, and assisted many ways with the transfer of patients to the new hospital.

ONTARIO

District 5

TORONTO

Women's College Hospital

Funds from the annual alumnae dance will be used for two scholarships and the Nurses' Education fund. Members are urged to send their talent money to the treasurer, L. Bernache, 49 Duggan Ave., before December 31, 1954; a greater response to this project is necessary if the amount required to furnish a room in the new nurses' residence is to be obtained.

Miss Von Tischler who won the Mary F. Bowman scholarship in '52 is studying for the Master's program in nursing administration at the University of Minnesota. Dr. M. Russell who interned at W.C.H. and has been doing missionary work in Africa visited Toronto recently. The new Marion G. Kerr scholarship, for post-graduate study in obstetrics, donated by Dr. M. Hilliard in tribute to Dr. Kerr, was awarded to D. Kimball. Mrs. (Kitchen) Morris is superintendent of a hospital in Sonora, California. Great credit is due Mary Deacon who studied for her degree in public health nursing at night for three years, working her way through University in California by nursing. On completion of her field work she will be a fully qualified P.H.N.

District 8

OTTAWA

Civic Hospital

At the 25th annual meeting of the alumnae association, it was noted that of the 1,528 graduates of the school of nursing, 443 were members of the association, 40 reinstated and 56 new members. Included among special speakers during the year were: E. Smellie, E. Horsey, and G. Cowieson. Special events were: Spring and fall teas, a rummage sale, bridge party and graduation dinner.

Recently, members were taken on a tour of the central supply room in the basement of the pathology building. Older graduates were especially impressed by the modern electric devices for cleaning, preparing and sterilizing equipment. Mrs. J. Argue was made chairman of the committee to collect funds for the purchase of a special projector costing about $400 to be presented to the new educational building. Fourteen members assisted the executive in convening the spring tea. President D. Ainger and Edith Young, director of nursing, received the guests and tea was poured by six other members.

The annual dinner in May was the occasion for reunions of classes '29, '34 and '44. 91 members of the 1954 graduating class were among the 327 guests. With

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Miss Ainger and Miss Young, others participating in the program were: S. Young, I. Comrie, M. Kemp, D. Poley, J. Perrin, Mmes D. (Bell) McKeown, J. (Donaldson) Scott, and D. (Slemon) Bruce. Professor Burke Ewing, M.D., F.R.C.S., guest speaker, delivered an inspiring address, and emphasized many characteristics that might be developed to make a truly satisfactory nursing career. E. Horsey, district president, was at the head table. The next day alumnae members were ushers at the graduation exercises when J. Deruchie, E. Langmyhr, D. Caverley, B. Aikenhead, M. Travis, E. Hodgins, and S. Black received awards. Bursaries of $800 from the hospital were awarded to M. Hutt and F. McLennan and covered one year post-graduate study in nursing education at an approved university.

During the past year money made at the gift and snack bar of the hospital was spent as follows: $1,000 for a loan fund for student nurses; $1,000 for special out-of-town courses for graduates; redecoration and various furnishings for the children's ward; furnishing of a sunroom and waiting room, East Lawn Pavilion; also other services such as free snacks for the out-patient department, transportation for needy cases, emergency layettes, and sweaters with crests for the student nurses' basketball team.

D. Smith is on staff at St. Paul's Hospital, Saskatoon. E. Barr completed her course in nursing administration and has joined the staff at O.C.H. M. Stitt is taking a course in anesthesia at Mercy Hospital, Detroit. M. Cooke is on staff at American Mission Hospital, Assiout, Egypt, and Mrs. J. (Maves) Dixon on that of Mt. Carmel Hospital, Detroit. Mrs. E. (Brady) Darling, class '34 and secretary of the Multiple Sclerosis Society, attended her 20th reunion in a wheelchair; in 1952 she received an award from the Civitan Club of West Toronto for her devotion to the relief of sufferers from the disease. Among those attending the C.N.A. biennial convention in Banff were: Miss Young, D. McPhee on behalf of the Indian Health Service Ontario Hospitals, J. Milligan, M. Anderson, J. Perrin, M. Lingard, E. Pepper, and other staff members.

District 12

Porcupine

The executive of the chapter for the coming year includes: Past chairman, Mrs. L. Avery; chairman, L. Birce; secretary, E. MacDonald; treasurer, I. Simister. Last year Mrs. Avery planned and successfully carried out a refresher course where an average attendance of 87 nurses received up-to-date information on new drugs and advances in nursing care; about 67 received certificates in Civil Defence and 37 completed the St. John Ambulance first aid course. With the generous support of local citizens, a bursary fund was established and will be used to help a worthy student in the completion of her hospital training.

QUEBEC

MONTREAL

Royal Victoria Hospital

66 preliminary students of the fall class were welcomed to the school of nursing at a tea recently.

Among the events in honor of Miss Grace Powell who left the hospital after 25 years' service were a tea and presentation by the staff nurses' association and a surprise shower and social evening by hospital friends prior to her departure to England.

K. Dickson has been appointed director of nursing at Grace Dart Hospital and E. Green has been sent to Alexandria, Egypt, with WHO. M. Coleman has joined the staff of University Hospital, Edmonton, and P. (Bourns) Corey that of St. Luke's Hospital, New York, while C. MacCallum is taking post-graduate study at McGill School for Graduate Nurses.

Recent visitors to the hospital include: M. Wardell on leave from mission fields in Guatemala; S. Rymer, VON, Smiths Falls; and E. (Illsey) Watt, J. Timmins, M. Baker, M. (Peters) Logan.

L. Beck is head nurse, Ward F.; assistant head nurses: J. Robertson, Ward F; C. Crimson, Ward J; S. Reid, Ward L; M. L. Black, Ward A; D. Robinson, Ward M. The following have joined the staffs of: Ross Pavilion, M. (Smith) Henderson; Allan Memorial Institute, J. Loney; Montreal Neurological Institute, A. Peterson, J. McAllister; cystoscopy department, Ward L, E. Rowsell; outpatient department, G. Boyd; central tumor registry, M. (Patterson) McNair.

SHERBROOKE

Sherbrooke Hospital

The following attended the C.N.A. biennial convention in Banff: C. Aitkenhead, director of nursing, C. Bernard, obstetrical supervisor, S. Carson, District 3 representative, and three student nurses representing the students' council, E. Husbands, B. Littlejohn and D. Aldrich. After the convention Miss Aitkenhead travelled to Alaska while Misses Bernard and Carson went to Vancouver and other points.

Miss Rae Chittick of the McGill School for Graduate Nurses was guest speaker at the graduation exercises for 18 members of the class in September. A reception followed the exercises and other activies included: a banquet and dance sponsored by the alumnae association, a luncheon by the local chapter of the VON, and a dance given by the governors of the hospital. A MacElrea is taking a course in teaching and supervision at the McGill School for Graduate Nurses.

SASKATCHEWAN

SASKATOON

The September meeting of the chapter was fairly well attended and following the reports of various committees, G. James and

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JEAN C. BROWN, REG. N.

Mrs. A. Caplin told about their trip to the C.N.A. Biennial convention at Banff. The three-day institute on "Scientific Nursing, Saskatchewan style," in September at the University of Saskatchewan was sponsored by members of the centralized lecture program staffs of Regina and Saskatoon and attended by about 45 nurses from various points. The topic of nursing science and its relation to nursing arts and the clinical field was well presented by lectures, demonstrations, discussions and group studies. Mr. M. Thompson, assistant director of provincial adult education, was a guest speaker.

St. Paul's Hospital

Sr. A. Lachance attended convention in Chicago recently. H. K. Hermanson, Presbyterian missionary at MacKay Memorial Hospital, Taipei, Formosa, has returned to the school for a refresher course. "Miss Annabelle Chase," nursing arts doll successor to "Mrs. Mary Chase," came to the school at the same time as 40 freshman B student nurses were welcomed to the new class.

City Hospital

D. (Reid) Wilson is proudly wearing the first "past president of the alumnae" pin, a regular school pin with insignia and double gold chevron with "Past President — Alumnae" engraved beneath. This is to be an alumnae institution, henceforth.

At the commencement exercises of the 1954 graduating class, the chairman was Brig. P. Reynolds while Dr. E. Peterson, president of medical staff, presented special awards, Mr. L. Muirhead, general superintendent, the diplomas, and Mrs. H. Armstrong, director of nursing, the pins. Dean N. Larmonth gave the invocation and J. Lindsay was valedictorian. L. Wright and M. King won scholarships for a year's post-graduate study in teaching and supervision at University of Saskatchewan, given by the board of governors. Miss King also received *The Canadian Nurse* award. Other prize winners were D. Nowlan, S. MacFarlane, A. Reid, L. Anear, S. Fingarson, D. Belliveau. A reception followed and guests were received by Mr. and Mrs. Armstrong and Mr. and Mrs. Muirhead. Alumnae members and staff doctors' wives performed tea honors assisted by student nurses. Graduate staff members were hostesses at the annual Mother and Daughter tea in honor of the class and a formal dance was sponsored by the board of governors and the student nurses' association. Thirty-nine students received their caps from Mrs. S. Paine assisted by L. Shackleton, president of the student nurses' association, at the Capping exercises in July. Mrs. Armstrong lighted the tapers and the Gideon Society presented white testaments while Mrs. J. Tansley of the society gave the address. M. Jira provided music and students under the chairmanship of M. Clarke presented a short program. One of the summer activities of the student nurses under the direction of M. Kearney was "Summer Serenade" with music conducted by M. Gunderson.

Mrs. J. Porteous, a former graduate and director of nursing, was guest of honor at the July meeting of the alumnae. M. Crawford has accepted a position in the new University Hospital and will be succeeded by Mrs. E. Dumas from Moose Jaw General Hospital as educational director. The following have joined the teaching staff: Mrs. B. Gilkinson from Winnipeg General Hospital and M. Allen, E. Scheu and D. Manson after completion of post-graduate studies at U. of S.

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Operating Room Nurse to act as Asst. Charge Nurse immediately for 100-bed Children's Hospital. Post-graduate course or previous operating room experience required. For information regarding salary & policies, apply Director of Nursing, Children's Hospital, 250 West 59th Ave., Vancouver 15, B.C.

Supervisors: Evening (1); Night (1); Operating Room (1). 86-bed General Hospital. Pleasant living conditions. Prettiest town in Manitoba. Salary open. Apply Supt. of Nurses, General Hospital, Dauphin, Man.

General Supervisors, Charge Nurses & General Duty Nurses for new 150-bed hospital. Starting salary for General Duty Nurses — $220 for B.C. Registered, with annual increases up to $30. 40-hr. wk. 1½ days cumulative sick leave. 28 days vacation. 11 statutory holidays. Apply Supt. of Nurses, Trail-Tadanac Hospital, Trail, B.C.

Obstetrical Supervisor for 70-bed General Hospital. Salary: $200 per mo. & up, depending on qualifications. Good personnel policies. Apply Supt., Ross Memorial Hospital, Lindsay, Ontario.

Science Instructor for Sept. Complete maintenance in comfortable suite. 120-bed hospital — 35 students. New 150-bed hospital under construction. Apply, stating experience & salary expected, Director of Nurses, Jeffery Hale's Hospital, Quebec City, Quebec.

Operating Room Supervisor for 220-bed hospital. Salary dependent on qualifications. Apply Director of Nurses, Grace Hospital, Winnipeg, Man.

Instructors for: Science Teaching followed by Clinical Ward Teaching; Clinical Ward Teaching & lectures in Medical Nursing. Commencing salary: $250 (additional for experience). Current R.N.A.B.C. contract in effect. 65 students; one class per yr. For information about position & community apply Director of Nurses, Royal Inland Hospital, Kamloops, B.C.

Operating Room Nurses. An interesting variety of experience is available to operating room nurses at the Montreal General Hospital. For further information, apply Director of Nursing, General Hospital, 60 Dorchester St. E., Montreal 18, Que.

HOSPITAL NURSES

GRADE 1 — $2,430 - $2,820 GRADE 2 — $2,730 - $3,120

Department of Veterans Affairs Hospitals

Camp Hill, Halifax
Ste. Anne's, Montreal
Sunnybrook, Toronto
Westminster, London
Deer Lodge, Winnipeg
Veterans Hospital, Saskatoon
Colonel Belcher, Calgary
Shaughnessy, Vancouver

Application forms, available at your nearest Civil Service Commission Office, National Employment Office or Post Office, should be filed with ***The Civil Service Commission, Ottawa.***

CIVIL SERVICE OF CANADA

Graduate Nurses (3) at once owing to present nursing staff leaving to get married. 30-bed hospital on C.P.R. main line & Trans-Canada Highway, 2 hrs. from Calgary. Modern nurses' residence & garage. 8-hr. day, 6-day wk. with rotating shifts. Starting salary: $170. $5.00 increase at end of each 6 mos. 3 wks. holiday & statutory holidays. Sick leave with pay & free hospitalization. Apply Matron, Municipal Hospital, Bassano, Alberta.

Graduate Nurses offered a six-month post-graduate course in Tuberculosis. Maintenance and salary as for general staff nurses; opportunity for permanent employment if desired. Spring and fall classes. For further information apply Baker Memorial Sanatorium, Calgary, Alberta.

General Duty Nurses for 110-bed hospital in scenic Fraser Valley, 65 miles east of Vancouver on Trans-Canada Highway. Salaries, holidays, etc., in accordance with R.N.A.B.C. personnel practices. Residence accommodation available. Apply Director of Nursing, General Hospital, Chilliwack, B.C.

General Duty Nurses for 430-bed hospital. Salary: $230-260. Credit for past experience. Annual increments. 40-hr. wk. Statutory holidays; 28 days annual vacation. Cumulative sick leave. Apply Director of Nursing, Royal Columbian Hospital, New Westminster, British Columbia.

Graduate Nurses for completely modern West Coast hospital. Salary: $230 per mo. less $40 for board, residence, laundry. $10 annual increments. Special bonus of $10 per mo. for night duty. 1 mo. vacation with full salary after 1 yr. service. 1½ days sick leave per mo. cumulative to 36 days. Transportation allowance not exceeding $60 refunded after 1st yr. Apply, stating experience, Miss E. L. Clement, Supt. of Nurses, General Hospital, Prince Rupert, B.C.

Graduate Nurses (3) for 24-bed hospital. Salary: $230 per mo. if B.C. registered; less $40 board, lodging, laundry. 1 mo. vacation after 1 yr. on full pay. 1½ days sick leave per mo. cumulative. Apply, stating experience, Matron, Terrace & District Hospital, Terrace, British Columbia.

General Staff Nurses for 400-bed Medical & Surgical Sanatorium, fully approved student affiliation & post-graduate program. Full Maintenance. Recreational facilities. Vacation with pay. Sick benefits after 1 yr. Blue Cross coverage. Attractive salary; 40-hr. wk. For further particulars apply Supt. of Nurses, Nova Scotia Sanatorium, Kentville, N.S.

General Duty Nurses. Salary: $182.43 (one hundred eighty-two dollars & forty-three cents) monthly, paid on a bi-weekly basis; 26 pays in a yr. Salaries have scheduled rate of increase. 48-hr. wk. 8-hr. broken day; 3-11, 11-7, rotation. Cumulative sick leave. Pension Plan in force. Blue Cross. 3 wks. vacation after 1 yr. service. Apply Supt. of Nurses, Muskoka Hospital, Gravenhurst, Ont.

Graduate Nurses for General Duty. Living-in accommodation if desired. Apply Supt. of Nurses, Homewood Sanitarium, Guelph, Ont.

GENERAL STAFF NURSES

GENERAL WARDS **OPERATING ROOM** **OBSTETRICS**

for

200-bed hospital

Pleasant city of 33,000. Two colleges.

Good salary and personnel policy.

For further information apply to:

DIRECTOR OF NURSES, GENERAL HOSPITAL, GUELPH, ONTARIO.

General Duty Nurses. Gross salary: $200 per mo. with 1 yr. or more of experience; $190 per mo. with less than 1 yr. experience; $20 per mo. bonus for evening or night duty. Annual increment, $10 per mo. 44-hr. wk. 8 statutory holidays. 21 days vacation & 14 days sick leave with pay after 1 yr. employment. Apply Director of Nursing, General Hospital, Oshawa, Ont.

Registered Nurses for 82-bed hospital. Gross salary: $210-230 per mo. 8-hr. day — no split shifts; 6-day wk. Rotating shifts. 30 days holiday with pay after 1 yr. service & all statutory holidays. Apply Supt. of Nurses, Union Hospital, Canora, Sask.

Registered Nurses for General Duty (2) for 30-bed hospital, Dryden, northwestern Ontario. Fully modern nurses' residence. Salary: $160 per mo. plus full maintenance. Salary subject to increase after 6 mos. with regular annual increases thereafter. 30 days vacation after 1 yr. service. Successful applicants reimbursed rail fare after 1 yr. Apply, stating age & when available, Supt., District General Hospital, Dryden, Ont.

General Duty Nurses (4) — Registered or Graduate — for 45-bed hospital. 8-hr. shift; 48-hr. wk. Salary: $210 per mo. gross. Increase of $5.00 per mo. after 6 mos. service. 3 wks. holiday with pay after 1 yr. service. Modern nurses' residence. Transportation refunded. Daily bus facilities to North Battleford & Saskatoon. Apply Matron, Union Hospital, Meadow Lake, Sask.

Registered General Duty Nurses (2), 76-bed hospital. Salary $220 per mo. $5.00 per mo. increase after 6 mos. service; 40-hr. wk; 2 wks. vacation and holidays with pay after one yr. Nice college town. Apply Director of Nursing Service, Jamestown Hospital, Jamestown, North Dakota.

Registered Nurses (2) immediately for 30-bed hospital within 1-hr. drive from Waterton National Park, ½-hr. from Lethbridge & 4 hrs. from Calgary & Great Falls, Montana. Salary: $175 per mo. plus full maintenance. Straight 8-hr. rotating shifts. 44-hr. wk. 3 wks. vacation with pay after 1 yr. plus all statutory holidays. Apply Matron, Municipal Hospital, Magrath, Alta.

Registered Nurses (2 or 3) for General Duty 18-bed hospital in beautiful Windermere Valley, B.C. Separate nurses' residence, fully modern. Salary: $220 per mo. less $50 full maintenance, subject to semi-annual increases. 28 days vacation after 1 yr. service; 2 wks. vacation at end of 6 mos. If desired, statutory holidays & 18 days sick leave per yr. cumulative. 8-hr. alternating shifts; 40-hr. wk. Good swimming, fishing, hiking; near radium hot springs; new modern theatre. Apply, stating age & when available, Mrs. D. Cookson, Matron, Lady Elizabeth Bruce Memorial Hospital, Invermere, B.C.

Registered Nurses for new 30-bed hospital. R.N.A.B.C. policies in effect. Apply Matron Creston Valley Hospital, Creston, B.C.

VANCOUVER GENERAL HOSPITAL

The Vancouver General Hospital requires:

General Staff Nurses. 40-hr. week. Salary of $231.00 as minimum and $268.50 as maximum, plus shift differential for evening and night duty.

New ***Paediatric Unit*** now open. Applications from qualified **Paediatric Nurses** welcome.

Residence accommodation is available.

Applications should be accompanied by letter of acceptance of registration in B.C. from *Registrar of Nurses, 1101 Vancouver Block, Vancouver 2, B.C.*

Apply to: **Personnel Dept., General Hospital, Vancouver 9, B.C.**

Nursing Arts Instructor for School of Nursing. 150 students—450-bed hospital. **Apply** Director of Nursing, General Hospital, Saint John, N.B.

Public Health Nurse — Grade I — British Columbia Civil Service, Dept. of Health & Welfare. Starting salary: $255-260-266 per mo. depending on experience, rising to $298. Promotional opportunities available. Candidate must be eligible for registration in B.C. & have completed University degree or Certificate course in Public Health Nursing. (Successful candidates may be required to serve in any part of province.) Cars are provided. 5-day wk. in most districts; uniform allowance; candidates must be British subjects under 40, except in case of ex-service women who are given preference. Further information may be obtained from Director, Public Health Nursing, Dept. of Health & Welfare, Parliament Bldgs., Victoria, B.C. Application forms obtainable from all Govt. agencies, Civil Service Commission, Weiler Bldg., Victoria, or 411 Dunsmuir St., Vancouver 3, to be completed & returned to the Chairman, Victoria, B.C.

Operating Room Nurse immediately. Salary commensurate with training. **Also Registered Nurses & Maternity Nurses.** Small General Hospital. Salary: $150 & $95 respectively, with full maintenance. 44-hr. wk.; 8-hr. duty; rotating shifts. 3 increments of $5.00 per mo. at 6-mo. intervals. Blue Cross. 10 days sick leave per yr.; 6 statutory holidays; 28 days vacation. Apply Acting Supt., Barrie Memorial Hospital, Ormstown, Quebec.

Nurse to direct Public Health Nursing program for Health Dept. of City of Calgary. Preference given to person holding degree or certificate in public health nursing with administrative & supervisory experience. 5-day wk. Sick leave & pension plan. 1 mo. holiday after 1 yr. Car provided. State salary expected. Apply Dr. W. H. Hill, City Health Dept., Calgary, Alta.

Public Health Nurses for generalized program — City of Ottawa Health Dept. Salary: $2,460-3,222 plus cost of living bonus (approx. $260 per yr.). Good personnel policies. Superannuation & Blue Cross benefits. Apply Employment & Labour Registry Office, Room 118, Transportation Bldg., 48 Rideau St., Ottawa 2, Ont.

General Duty, Operating Room & Obstetrical Nurses. Salary: $200 for recent graduates Laundry. 8-hr. day, 44-hr. wk. — straight shift. $20 differential evenings — $15 nights. Vacation, sick time, statutory holidays on salary. Semi-annual & annual increments. Financial recognition for yrs. of experience, post-graduate or university study. Apply Director of Nursing, General Hospital, Winnipeg, Man.

Registered Nurses for General Duty & Operating Room. Busy 70-bed hospital. Commencing salary: $180 & up. Good personnel policies. Apply Supt., Ross Memorial Hospital, Lindsay, Ont.

School of Nursing, Metropolitan General Hospital

WINDSOR, ONTARIO

Positions open: **CLINICAL INSTRUCTOR IN SURGICAL NURSING**
HEALTH INSTRUCTOR

This is a new school taking in 32 students once yearly, with opportunity for the faculty to participate in the development of the curriculum upon sound educational lines.

For further information apply to:

Director, School of Nursing, 2240 Kildare Road, Windsor, Ontario.

General Duty Nurses — "You will like it here." Placement in the service of your choice in Teaching Hospital. Beginning salary: $240 per mo. for 40-hr. wk. Scheduled increases, payment for overtime, 6-hr. evening duty. $270 per mo. for night duty. Sick leave, 6 holidays, 3 wks. vacation. Residence facilities if desired. Tuition-free courses after 6 mos. service. Opportunities for advancement. Apply Director of Nursing Service, University Hospitals of Cleveland, Cleveland 6, Ohio.

General Duty Nurses for Medical, Surgical, Pediatrics, Obstetrics. Good salary & personnel policies. Apply Director of Nursing, Victoria Hospital, London, Ont.

Registered Nurses for General Duty Staff. Salary commences at £40-10-0 per mo. with full maintenance. Transportation allowance. For full particulars apply Matron, King Edward VII Memorial Hospital, Bermuda.

General Duty Nurses (2) — one each for Oct. & Nov. Salary: $180 per mo. plus full maintenance. 3 increases of $5.00 per mo. for each yr. experience to a maximum of $195. 3 wks. holiday with pay plus all statutory holidays. Separate nurses' residence. Apply Matron, Municipal Hospital, Fairview, Alta.

Clinical Instructor — Medical Area in modern 400-bed hospital. Applications are now being considered. Salary commensurate with experience & qualifications. Address correspondence to Director of Nursing, Kitchener-Waterloo Hospital, Kitchener, Ont.

Public Health Nurse for generalized program in Prince Edward County Health Unit. Initial salary: $2,600; allowance for experience. Employee benefits include: Blue Cross, pension plan, sick leave, 1 mo. vacation. Workmen's Compensation. Liberal allowance for transportation. Apply A. M. Breuls, M.D., Director, Prince Edward County Health Unit, Picton, Ont.

Night Supervisor for 50-bed hospital. Good Salary; full maintenance in new Nurses' Residence. Apply W. A. Oakes, Clinton, Ont.

Registered Nurses (2) to commence duties immediately. Salary: $220 per mo. less $35 per mo. for full maintenance. Living accommodation at present in hospital building. Fare refunded after 1 yr. service. 28 days holiday per yr. & statutory holidays. 40-hr. wk. Attractive community & social life. Apply Sec., General Hospital, Golden, B.C.

Operating Room Supervisor. Experienced. Post-graduate preferred. New 111-bed hospital. Minimum salary: $260; maximum depending on qualifications & experience. Apply Administrator, West Coast General Hospital, Port Alberni, B.C.

Public Health Nurses (qualified) for City of Oshawa. **Two vacancies.** Generalized program in urban area. Minimum salary: $2,700; allowance for experience. Transportation provided. 5-day wk; 4 wks. vacation; sick leave with pay; pension plan. Hospital insurance. P.S.I. available on participating basis. Apply Board of Health, Oshawa, Ontario.

Registered Nurses for General Duty (3) for 24-bed hospital. Salary: $225 per mo. plus full maintenance. Rotating 8-hr. shifts; usual holidays with pay; courtesy hospitalization; transportation refunded after 1 yr. Apply in writing, Sec., Municipal Hospital, Mannville, Alberta.

McKELLAR GENERAL HOSPITAL, FORT WILLIAM, ONTARIO

Requires the services of

A QUALIFIED AND EXPERIENCED GRADUATE NURSE

As **SUPERVISOR** of a 20-bed Isolation Unit

Salary commensurate with experience. 28 days vacation; 8 statutory holidays. Sick leave accumulative to 60 days; hospitalization benefits; residence accommodation; transportation refunded. New, modern, well equipped and staffed 435-bed hospital.

Apply:

MISS GRACE E. JOHNSON, DIRECTOR OF NURSING

Operating Room Nurse, Registered Graduate Nurses, Catherine Booth Graduates & Trained Attendants for new hospital, 68 miles from Montreal. Excellent bus & train service. Salaries in accordance with A.N.P.Q. personnel policies. Full maintenance. 8-hr. duty; rotating shifts; 1½ days off per wk. 30 days annual holiday plus 7 statutory holidays. 12 days sick leave allowance. Blue Cross paid. Apply Supt., Brome-Missisquoi-Perkins Hospital, Sweetsburg, Que.

Registered Nurses (2) for 22-bed hospital, preferably with Operating Room experience. Good salary & reasonable maintenance. 44-hr. wk. 28 days vacation with pay after 1 yr. service; 7 statutory holidays. Apply, giving qualifications & references, Bruce Peninsula & District Memorial Hospital, Wiarton, Ont.

Additional Nurse Instructors for the Mental Hospital Service to instruct mainly undergraduate nurses. Gross starting salary, including cost-of-living bonus: $2,860 per annum, with annual increases. Residence accommodation available, if desired, at nominal rates. 3 wks. annual vacation. Sick leave benefits. Superannuation scheme. Apply Mental Health Division, Parliament Bldgs., Toronto 2, Ont.

Graduate Nurses for General Staff Duty in 350-bed Tuberculosis Hospital in Laurentian Mts. For further information, apply Director of Nursing, Royal Edward Laurentian Hospital, Ste. Agathe des Monts, Quebec.

Public Health Nurses (4) for Porcupine Health Unit which is extending to include Kapuskasing, Smooth Rock Falls, & surrounding unorganized territory. Attractive working conditions. Good salary; 5-day wk; 4 wks. annual vacation. Car provided. Special allowance for French-speaking nurse. Apply Sec., Porcupine Health Unit, 164 Algonquin Blvd. E., Timmins, Ontario.

Director of Nurses, capable of supervision of the Nursing Services of a hospital with 105 beds and 19 bassinets. In reply state qualifications, references to the Administrator, Cottage Hospital, Pembroke, Ontario.

Instructor for School of Nursing. Applications are invited for this position at King Edward VII Memorial Hospital — 138 beds — affiliated with Montreal hospitals. This school is affiliated with teaching schools associated with McGill University, Montreal. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

Operating Room Nurse (experienced, preferably with post-graduate course); **Operating Room Staff Nurses.** Opportunity for advancement. Full maintenance. Travel allowance. For full particulars, write Matron, King Edward VII Memorial Hospital, Bermuda, giving particulars & date available.

Nursing Supervisor for Active Treatment Wards at Manitoba Sanatorium, Ninette, Man. Preference for previous supervisory & chest surgical nursing experience. Salary range: $245-265 per mo. Board, room & laundry — single rooms in new nurses' home supplied for $45 per mo. Generous vacation with pay, group insurance, all statutory holidays & other employee benefits. Apply Sanatorium Board of Manitoba, 668 Bannatyne Ave., Winnipeg, Manitoba.

POSITIONS VACANT

Public Health Nurses (25) & vacancies for staff appointments (5) in North York (adjacent to Toronto), due to population increases of 75,000 in 5 yrs. Starting salary for experienced successful applicants: $3,520 including car allowance. Generalized program. 35-hr. wk. 4 wks. vacation with salary; cumulative sick leave. Free hospitalization insurance; pension plan; group life insurance. Small suburban districts are available. Address inquiries to Dr. Carl E. Hill, Medical Officer of Health, 5248 Yonge St., Willowdale, Ont., & interviews can be arranged before appointments.

Supt. of Nurses for fully staffed new 56-bed hospital. Private suite in separate nurses' residence. Starting salary: $190 plus full maintenance. M.H.S.A. & M.M.S. half paid by hospital. 3 wks. vacation with pay 1st yr. employment; 4 wks. after 2nd yr. Regular sick leave. Apply Sec.-Treas., District General Hospital, Morden, Man.

FOR RENT

First-class Convalescent Home, Niagara district. This is a fine opportunity for married Registered Nurse and husband. Apply Mrs. J. G. McDonald, 171 Killaly St. W., Port Colborne, Ont.

Nurse Wanted — to rent brick residence for Nursing Home. 11 rooms on 2 floors. Please write R. Mason, Box 688, Port Dover, Ont.

Ancient Remedies

DR. R. A. HAKIM is a psychiatrist working at the Mental Hospital of Ahmedabad in India. He decided to test the value of a group of traditional native herb remedies, reference to which are found in the *Ayurveda*, the centuries-old Hindu holy book of long life.

He separated 146 mental patients—among them schizophrenics, hysterics, and other serious cases—into three comparable groups, prescribing different treatment for each. One group was given electric shock therapy, a standard method of treating mental patients in hospitals all over the world; to the second group he administered several *Ayurvedic* herb drugs; and the third underwent a combination of the two therapies.

The results are astonishing. Whereas the recovery rate of the group on electric shock treatment was just a little over 30 per cent, patients receiving *Ayurvedic* drugs had a 50 per cent recovery rate. But the third group, treated with the combination, had a recovery rate of more than 80 per cent.

More experimentation and study are necessary before general conclusions can be drawn about the value of these ancient drugs in the treatment of mental disease, but the work of Dr. Hakim has aroused much optimism, especially since he achieved highly encouraging results in schizophrenia.

Should the *Ayurvedic* drugs fulfill their promise, it will not be the first time that modern medicine has drawn on the wisdom of the past. For example, certain plants of the *Datura* family, to which the potato belongs, were used by the Indians of Central America as narcotics and hypnotics long before scientists learned that they contain such potent drugs as atropine and belladona. It was only in the 18th century that the world at large discovered the quinine-containing cinchona bark, used for centuries by the Indians of South America to combat malaria.

There are many other examples. The traditional practice among Balkan peasants of applying stale, moldy bread to wounds is, in a sense, a forerunner of modern antibiotic therapy. The stale bread derives its infection-fighting power from germ-killing substances produced by the mold that covers it. It was in a species of bread mold that scientists discovered the first antibiotic—penicillin—a forerunner of even more potent "miracles from molds" such as terramycin.

All this has served to alert today's researchers to the fact that ancient remedies, no matter how strange they may seem to 20th century science, may lead to important new discoveries.

— *SIS Medical Features*